ANZCA
FPM

Bulletin

Australian and New Zealand
College of Anaesthetists
& Faculty of Pain Medicine

WINTER 2022

How a trainee project became a frontline resource

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Living and working on the edge in New Zealand's South Island

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ANZCA Bulletin
The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain medicine physicians. ANZCA comprises about 7500 fellows and 1700 trainees mainly in Australia and New Zealand. It serves the community by upholding the highest standards of patient safety.

Medical editor: Dr Tanya Selak
Editor: Clea Hincks
Production editor: Liane Reynolds
Feature writers: Carolyn Jones & Adele Broadbent
Advertising manager: Vivienne Forbes
Designer: Frances Rowsell

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Contact us
ANZCA, 630 St Kilda Road, Melbourne
Victoria 3004, Australia
+61 3 9510 6299
communications@anzca.edu.au
www.anzca.edu.au

Faculty of Pain Medicine
+61 3 8517 5337
fpm@anzca.edu.au

Cover: Producing a companion video to a cognitive aid for the safe tracheal intubation of COVID positive patients during the first wave of 2020.

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New president for our 30-year-old college

TO MARK MY first president's message for the *Bulletin* – which coincides with the 30th anniversary of ANZCA – I would like to start with a quick historical overview of our college.

In 1952 anaesthesia was established as a faculty of the Royal Australasian College of Surgeons and it took 40 years for us to evolve into a separate college in 1992. The 18 deans elected to the new faculty sound, not surprisingly, like the names of the many prizes and awards ANZCA now presents every year.

The number of fellows grew from 69 foundation members in 1952 to more than 2000 by 1992. With more than 7000 fellows in 2022 we are now one of the largest specialist medical colleges in Australia and New Zealand.

The Faculty of Pain Medicine pioneered the first training program in the world in 1998 and has trained hundreds of specialist pain medicine physicians since recognition as a specialty in Australia in 2005.

Like many 30-year-olds, who are established and have done the hard yards, we can now look forward to a period of consolidation and an expansion of our horizons.

I'm a clinical anaesthetist from Perth in Western Australia so the presidential medal has relocated from New Zealand in the eastern reaches of the ANZCA empire to the western.

I work predominantly in public at the Fiona Stanley Fremantle hospital group but also in private.

My main interests are in cardiothoracic anaesthesia and I am co-head of one of the largest departments in Australia and New Zealand.

My pathway to this job has not been straightforward. I haven't always been involved with the college and came to ANZCA Council relatively late after a gratifying term as a final examiner.

In fact, I was actually quite anti-college when I finished my training and saw it as a mainly Melbourne-based club of little relevance to me. I have changed my thinking since then and believe my unorthodox pathway is an advantage in bringing a different perspective to the role.

I am honoured to be the 18th president of ANZCA during our 30th anniversary and, after me, the presidents will outnumber the deans.

The college is an impressive organisation full of remarkable people. I don't think I've ever attended a meeting or heard a discussion where the interest of fellows, trainees or the public have not been placed front and centre.

This is one of the reasons ANZCA is held up as one of the leading specialist medical colleges and we are seen as leaders, innovators and responsive to our environment.

Diversity and equity among our trainees and fellows are areas where we need to improve. I understand some of this is beyond our control, and it will take time, but I would like to be confident we are on a trajectory that will ensure our membership mirrors the general population in the near future.

> "Like many 30-year-olds ... we can now look forward to a period of consolidation and an expansion of our horizons."

During my tenure I'd like to focus on three objectives.

COVID-19 has disrupted everything but, as travel begins again, I would like to reconnect with fellows from around Australia and New Zealand including those outside the big cities. I plan to share these activities with my predecessor Vanessa Beavis so she can experience some of the things COVID-19 stopped us from doing.

Secondly, I have been very impressed and proud of the way our fellows and trainees have conducted themselves during the pandemic. We have stood up and helped out in intensive care, emergency, on the wards and in continuing to perform our planned and elective workload.

This professionalism, willingness and flexibility have been recognised and I hope we can continue to be the "can do" specialty we have demonstrated we are. Never let a crisis go to waste so the introduction of our diploma in perioperative medicine in the near future provides us with a handy tool to build on this foundation.

My last wish is more of an acknowledgement and awareness of consultant wellbeing.

Over my career I have come to realise we struggle with processing poor clinical outcomes, particularly if we feel personally responsible. I say this from my own experience and from witnessing the effects of these episodes on other colleagues.

As a group I would like us to accept that we will experience these events during our career, and to make sure we communicate and ask for help when needed and access the many resources that are available.

I think the primary reason we're not well prepared for these events is largely because they are thankfully very rare.

Before I finish, I cannot overstate enough the efforts of our huge and enthusiastic volunteer workforce and acknowledge we could not function as a college for a single day without you.

I look forward to your support, the support of council and our CEO Nigel Fidgeon over the next two years.

Thank you and I will endeavour to do my very best in the interests of our fellows and trainees during my term.

Dr Chris Cokis
ANZCA President

2022 ANZCA National Anaesthesia Day

While many of you have experienced workforce pressures due to the pandemic we hope that some of you will be able to join us in celebrating National Anaesthesia Day 2022.

ANZCA will send posters and other material to hospitals in late September.

Visit www.anzca.edu.au/NAD for more information or email communications@anzca.edu.au.

- ☐ Mark Monday 17 October in your diaries.
- ☐ Nominate someone to organise your activities.
- ☐ Book your hospital foyer space.

The theme for this year is

"Anaesthesia and children"

A new ANZCA patient information video will be launched in time for #NAD22 so start thinking about your displays now.

National Anaesthesia Day is held each year to raise awareness of the crucial role anaesthetists play in healthcare.

An ANZCA initiative, National Anaesthesia Day is usually held each year on 16 October to mark the anniversary of the day in 1846 that ether anaesthesia was first demonstrated publicly. Due to 16 October falling over the weekend we will celebrate on Monday 17 October.

College priorities on the fast track

AS 2022 CONTINUES to race along it has become ever apparent that we have now entered into the next iteration of living with the pandemic. College activities continue to emerge from the shroud of the past two years with staff returning to our offices across Australia and New Zealand. We are still cautious and ever mindful of winter and the potential challenge that a flu season may bring.

It has been pleasing to see a staged return of face-to-face events and some college meetings that our fellows and trainees have embraced. We are also adjusting to our new "hybrid world" with its use of online platforms now routine to complement our face-to-face gatherings. A number of key face-to-face events are planned throughout 2022 with further details about these on the events tab on our website. The recent 2022 ANZCA Annual Scientific Meeting (ASM) again showcased an impressive program of scientific content that was extremely well received with more than 1700 registered attendees, 250 speakers, presenters, contributors and facilitators.

There is now more than 80 hours of online ASM content available over the next 12 months or so which can now be accessed through a user-friendly mobile app that allows easy viewing on mobile devices. The 2023 Sydney ASM has also been launched and is shaping up to again be a combination of face-to-face and online content for registrants.

Planning for a new 2023-2025 college strategic plan is under way with the existing five-year plan due to end this year. Consultation across council and the faculty with input from the college's 2021 fellows' survey is providing invaluable insight in identifying priorities for the new plan. It is planned that this new strategy will be approved in July and then distributed to college members.

Many of the college's strategic priorities have meanwhile continued to be advanced, notably in the education arena with the new diploma of rural generalist anaesthesia soon to take enrolments for the start of the 2023 hospital employment year. ANZCA continues to work in collaboration with the Royal Australian College of GPs and the Australian College of Rural and Remote Medicine to deliver this qualification. Further information is available on our website.

In addition, progress continues with the development of the perioperative medicine qualification due for launch in late 2023. Ongoing collaboration with the College of Intensive Care Medicine is progressing so a dual training program can be developed between our two colleges.

All these education deliverables will be underpinned by the Lifelong Learning Project that will ensure all core college information systems can either be replaced or upgraded. This investment by the college will deliver a fit for purpose, contemporary information system to support all college core activities and replace disparate systems that don't always deliver the functionality we now need.

Work is well advanced on the exam management system option for online examination platforms following recent testing of a trial online exam platform by examiners and staff. The next step is to progress the required functionality and integrity required for online examinations.

The education team is also working with the Faculty of Pain Medicine on the proof of value for the training performance system to transition from a paper-based system to an electronic platform for the Procedures Endorsement Program in Pain Medicine. Once finalised this system will be rolled out across the college.

The existing ANZCA continuing professional development (CPD) system is also being upgraded to ensure compliance with the requirements of the Medical Board of Australia CPD requirements in 2023. The learning management system will closely align with the CPD system and will deliver a more user friendly, fit for purpose resource to replace the existing ANZCA Networks.

Delivery of the 2022.1 exams has been a success, allowing progression of our trainees. Once again, this has only been achievable thanks to the efforts of the final and primary exam committees, the court of examiners and ANZCA staff who have all worked tirelessly to deliver exams throughout the pandemic.

The college is about to undertake a full accreditation process by the Australian Medical Council (AMC) for all ANZCA education qualifications. A comprehensive and extensive report was submitted to the AMC in early April ahead of the July process. This will occur as combined face-to-face and virtual visits of ANZCA training sites and interviews with regional committees, council, faculty and staff.

As we are halfway through 2022 college activity continues at a fast pace by responding to key stakeholder consultations, advocacy and promotion of the role of anaesthesia, pain medicine and perioperative medicine, all in a tumultuous external environment.

Nigel Fidgeon
ANZCA Chief Executive Officer

Letters to the editor

DESFLURANE CANCEL CULTURE

I have watched with considerable interest an emerging enthusiasm to cancel desflurane from anaesthetic use due to its relatively high production of CO2 emissions even at low fresh gas flows and end tidal monitoring.

While I acknowledge this potential environmental impact my individual use persists for patient safety concerns, namely the rapid emergence from anaesthesia and return of protective functions upon arrival at a recovery area of increasingly unfamiliar staff with variable experience and competence.

Forbes McGain in a 2020 BJA article invoked informed choice (not cancellation) in the reduction of an environmental footprint.

Emerging work on waste gas scavenging, destruction and recycling is conveniently absent from the current movement.

So let's not yet so zealously throw the baby out with the bathwater.

Dr Anthony Archer FANZCA DipRACOG
Anaesthetist in private practice
Adelaide

Reference

British Journal of Anaesthesia,125 (5): 680-692 (2020) Environmental sustainability in anaesthesia and critical care Forbes McGain, Jane Muret, Cathy Lawson and Jodi D Sherman.

THE ADVANTAGES OF DESFLURANE

The Autumn *ANZCA Bulletin* makes interesting and enlightening reading.

Thank you to all involved.

The thorny issue of desflurane is covered well in two articles in this edition.

I commend the authors for these articles, and their environmental focus on the healthcare sector in general, and the anaesthetic contribution to environmental degradation in particular.

I acknowledge the obvious environmental problem with desflurane, and to a lesser, but significant extent other anaesthetic gases, of which only two, sevoflurane and nitrous oxide are commonly used in current first world practice.

However, I would question the sentiment that TIVA is universally, in current anaesthesia, invariably the best, and indeed as promoted, the only way forward in our specialty.

There are many ways to provide anaesthesia, and it is somewhat presumptive and arrogant for those promoting a certain style of anaesthesia to assume that it is the best, and only acceptable technique, and enforce their belief on all by a steady campaign for withdrawal of resource.

This is in play at several metropolitan hospitals in Victoria – one of which; a smaller private hospital that I work at, has just placed the desflurane Vaporisers under lock and key to be signed out when needed.

And yet, in the tearoom, all items associated with food and drink are disposable; the mountain of disposable surgical equipment and drapes at the end of each case is huge, where 20 years ago, much of this would be recycled, and there is minimal recycling of anaesthetic equipment and accessories; some of which with a little effort would be entirely appropriate to be recycled.

At the end of the list I return to the car park to retrieve my bike chained to a rail, bordering a car park full of doctor stickered cars, with no designated zone at the hospital for bike parking.

Another major Victorian teaching hospital has withdrawn desflurane entirely, and has deemed nitrous oxide redundant.

Trainees therefore get a blinkered and narrow TIVA focused base to their training, which may be fine for first world anaesthesia, but fails to address the ability to provide anaesthesia globally, for example, the fine work provided pro bono by current Victorian anaesthetists in the Pacific and Asia.

As stated in one of the Autumn *Bulletin* articles, desflurane is a low hanging fruit, easy to pluck and produce a warm, feel good, virtue signalling state in said pluckers.

I would argue that desflurane has significant advantages, compared to TIVA in certain situations involving relaxant general anaesthesia; particularly orthognathic surgery and anaesthesia for the morbidly obese, with that other pariah, nitrous oxide, which in my practice still has significant relevance in 2022.

Naturally this is all with ultra low flow anaesthesia, awareness of the environmental impact, and recycling anaesthetic accessories where possible, to minimise the plastic mountain that anaesthetists create every day with the single use mantra so entrenched in current practice.

The cynic in me posits that hospitals take up the desflurane bashing role enthusiastically, not in the name of environmentalism, where in every other area of their functioning this sentiment is completely non existent, but for fiscal reasons, and the advantage to their bottom line, in view of the ridiculous price of a bottle of desflurane, which will doubtless plummet as it becomes generic.

I maintain that desflurane should not be removed from current practice, as predicated by some enthusiasts, and that it has an important role to play, in contemporary practice if used with due care and sensitivity, and that absorbent filters be fitted to anaesthetic circuits to prevent extravasation of the exhaust gas to the atmosphere.

Recent application of ultra filters for the COVID-19 virus may lead the way here.

There are many ways to skin a cat, or provide an anaesthetic with due care and attention. Dogmatic monotheism and the desire to enforce a particular cult following on all is, at the very least, problematic, and, upon reflection, a cause of untold trouble and anguish in the current world.

Dr Stuart Skyrme-Jones FANZCA,
Richmond, Victoria

MENDELSON'S SYNDROME

In the 2021 Summer edition of this *Bulletin* I suggested that the modified rapid sequence intubation technique, using rocuronium, was an inferior pathway for the protection from and prevention of Mendelson's syndrome.

In the Autumn 2022 edition, in the Safety and Quality section, SCIDUA highlights just such a failure of this technique.

In the same edition, Dr Stuart Skyrme-Jones advocates the use of rocuronium, and only rocuronium, in obstetrics. He then states that suxamethonium should "be retired to the museum".

I would suggest that this is an extrapolation from a very specific use of this (his) technique.

I would hope that anaesthetists do not relegate suxamethonium to history from this example.

Firstly, it is in obstetrics. The patients are fit and young.

Secondly, Dr Skyrme-Jones stuns the neuro-muscular junction with a pre-treatment of a muscle relaxant. This historical use of muscle relaxants will have to be explained to the vast majority of today's anaesthetists.

I would suggest this is the technique that should be relegated to history.

Finally, he uses a large dose of propofol for induction. Suitable for fit young patients, dubious in most cases of small bowel obstruction.

I am sure Dr Skyrme-Jones has developed a suitable technique for his patients.

However he has tweaked the modified rapid sequence intubation for a specific anaesthetic.

A technique that needs to be tweaked, even for fit young patients, only confirms that the universality of the technique is wanting.

Dr David Cay FANZCA
New South Wales

CONFRONTING SUICIDE

I read the obituary in the Autumn 2022 *Bulletin* with dismay. Dismay at the tragic loss of a spectacular individual, but in particular, at our inability to confront the problem. The obituary paints a terrific picture of a talented adventurous man, cool and sporty, innovative and supportive, and a fantastic colleague. His family and friends must be devastated, and we feel their pain. The author, clearly shocked by the loss of his friend, hints at what I assume was a life troubled by mental illness, and a death by suicide. The phone numbers for Lifeline and other support programs leave little doubt.

This is by no means the first such obituary in the *Bulletin*, where suicide is intimated, and the reader is left to infer. Sometimes this has been to "protect" the families, for "privacy", or whilst awaiting a formal coronial inquiry, but why must it be so hard for us to name this particular cause of death? It is most definitely not the first *Bulletin* obituary of a colleague dying by suicide. There have been *Bulletin* obituaries that confront suicide head on, and others like this one that are more circumspect. But however we write about our dear colleagues, we can be sure that some will continue to die by their own hands.

Why are so many anaesthetists dying in such a way? Why do we all know friends and co-workers who have died by suicide? I don't have any data, but I lost two fellow registrars to suicide. I am not alone.

What is wrong with our profession that this seems to be a regular occurrence? Are there factors in common from which we can learn? Should we treat this not as a problem for at-risk individuals, but rather as an issue that binds us all? Are our collective obsessions with tinkering and gaining immediate control interfering with a healthy aspiration for long-term wellness and contentment?

Is this something almost fundamental within anaesthesia? If so, what are we all going to do about it?

Anaesthesia bravely confronted the issue of drug addiction in the early 1980s. We spoke about something that destroyed lives in our craft group, and in our workplaces, and in our families. Since then, we have specifically and openly dealt with issues that we now take for granted: issues such as safety, bullying, and competence. It is past time to confront mental illness, but more explicitly, that we are killing ourselves. It is time to ask what we need to change in our workplaces and cultures and practices to protect all of us from ourselves.

Dr Rob Burrell, FANZCA
Auckland

Dr Gibbs responds

In relation to obituaries in the *Bulletin* Dr Burrell asks "... but why must it be so hard for us to name the cause of death?" This question is based on a mistaken premise. In an obituary it is not '"so hard" to name a particular cause of death. It is just unnecessary. An obituary is about a person's life, not their death. It is not a platform to make a point. There are also many other sources of information on causes of death. Moreover, while I endorse Dr Burrell's comments and recognise that much further work is required, perhaps he should acknowledge the many resources already in place at department, state, and national levels in this regard, and in particular the activities and initiatives introduced by both ANZCA and the ASA.

Dr Neville Gibbs, MBBS, MD (UWA), FANZCA, MSc (Oxon)
Perth, Australia

2022 Queen's Birthday Honours

Congratulations to our Australian fellows recognised in this year's Queen's Birthday Honours.

Medal in the General Division (OAM)

- **Dr Michelle Janice Mulligan**, FANZCA, FAICD, NSW.
  For service to medicine, particularly to anaesthesia.
- **Dr Jennifer Stedmon**, FANZCA, FAICD, WA.
  For service to medicine in the field of anaesthesia.

ANZCA Staff Awards

Earlier this year we held the annual ANZCA Staff Awards at ANZCA House in Melbourne. We'd like to congratulate the winners of the 2021 awards:

Mathew McGuire
Education and Research Customer Service Award

Mat was recognised for his work in supporting fellows and continuing professional development (CPD) participants with the Customer Service Award. During the past two years of the COVID-19 pandemic, Mat has set a new standard for the level of service in CPD, leading to outstanding results in CPD compliance. For the 2019-2021 CPD triennium and the 2021 verification (audit) there was a 100 per cent completion rate.

Sadly Mat recently left the college. We wish him well for the future.

Eric Kuang
Corporate Services Innovation or Process Improvement Award

Eric has shown exemplary innovation in the Environmental Sustainability Network setup, lifelong learning project and continuing professional development (CPD) processes.

This year, Membership Services worked with Eric to set up a new way for fellows to engage with the college, via a network. Eric identified solutions within the current information and communications technology structure that will enable a large and dynamic network of members to receive updates and communications based on their preferences, enabling the college to move forward with its plans to become a leading voice in environmental sustainability in anaesthesia.

In-House Events Team
Fellowship Affairs Team Award

Katie Fagan, Fran Lalor, Kate Chappell, Bianca Parker, Michelle Williams, Majella Coco, Sarah Chezan, Kirsty O'Connor, Elodie Cobo-Garcia, Kate Galloway and Jan Sharrock received the Team Award for their work on the 2021 ANZCA Annual Scientific Meeting (ASM). In 2021, the ANZCA in-house events team delivered the first ever virtual ASM, run from a central hub in Melbourne and across hubs in Australia and New Zealand. In eight months, the team turned a five day, in-person meeting into an eight day fully virtual meeting.

Changes to council

In May Dr Chris Cokis from Perth took over from Dr Vanessa Beavis as the latest president of a new-look ANZCA Council.

We welcome and farewell a number of councillors and thank them for their commitment to anaesthesia, pain medicine and perioperative medicine.

Thank you to our pandemic president

I HAVE HAD the honour over the last two years of being the vice-president under Dr Vanessa Beavis and have observed first-hand her skills as a leader in some of the most extraordinary circumstances any president of ANZCA has faced.

Most of us will remember the beginning of the pandemic in March 2020 when the future was unclear and toilet paper had disappeared off the shelves. Despite presiding over a council who had never physically met, Vanessa took the helm in May and ably navigated the college through the difficulties we faced.

Vanessa had the opportunity to hone her skills over her 15-year tenure as the director of perioperative services at Auckland City Hospital, a culmination of a career that began in South Africa before a move to New Zealand in 1993 as a specialist anaesthetist with an interest in liver transplantation.

Following a stint as a final examiner Vanessa joined ANZCA Council in 2012 and, in her usual style, quickly established a reputation as a hard-working and no-nonsense councillor.

The almost existential threat at the beginning of the pandemic highlighted Vanessa's talent in negotiating fearlessly to reach a good outcome.

As the old saying goes "Cometh the hour, cometh the (wo)man".

The future of training, and of exams in particular, was suddenly in limbo as hospitals had stopped rotations, borders had closed and travel had effectively ceased. The usual travel intensive examination process had stalled and there was a real fear trainees would not progress leading to a shortage of qualified specialists.

Amongst, almost unheard of, emergency and late night (very late night in NZ) council meetings, meetings with examiners, trainees and educational staff at the college, Vanessa negotiated, brokered and weaved a pathway through to allow trainees to continue training. This resulted in minimal disruption to our training program, a result far better than most other colleges.

Amongst Vanessa's proudest achievements was announcing a Māori name for the college "Te Whare Tohu o Te Hau Whakaora" which perfectly encapsulates what we are and what we do (see the Autumn 2021 *ANZCA Bulletin*).

This was a milestone event for the college, cementing Māori culture and language into our future, a leading example for Australia to follow.

During 2021 Vanessa became the inaugural Chair of the International Academy of Colleges of Anaesthesiologists (IACA) an international collaboration of five specialist anaesthesia colleges with ANZCA as a founding member.

This important union promises to keep us engaged with our sister colleges so we may share those elements common to all of us.

Vanessa's other achievements include her long-standing advocacy for the development of a diploma in perioperative medicine which, having being promoted in the last two presidents' inaugural *Bulletin* articles, will hopefully come home to roost during my term.

Aside from her leadership and communication skills Vanessa shared other talents including an innate sense, when moving councillors and fellows onto committees, of balancing the various personalities with the roles and responsibilities required of them.

During our weekly briefings Vanessa showed her sharp sense of humour, called a spade a spade and during meetings could quickly read the room even through the lens of Zoom.

She formed a formidable team with Mick Vagg, the immediate past dean of FPM, further cementing the close relationship between the college and the faculty.

Vanessa, we look forward to your remaining time on council, continuing to benefit from your common sense and wisdom.

I will summarise your legacy with these words:

"He aha te kai a te rangitira? He korero, he korero, he korero" ("What is the food of leaders? It is communication").

Dr Chris Cokis
ANZCA President

> "During our weekly briefings Vanessa showed her sharp sense of humour, called a spade a spade and during meetings could quickly read the room even through the lens of Zoom."

Departing councillors

ANZCA fellows look to their council for guidance, knowledge and advice on key issues and practices in anaesthesia. Here, we farewell four councillors and acknowledge their significant contribution.

DR ROD MITCHELL

Dr Mitchell was elected to ANZCA Council in 2010 and took office as ANZCA president in May 2018 for two years. As an ANZCA councillor, including his time as president, he focused on promoting improved equity of access to healthcare, particularly for rural, Indigenous and Māori communities, and to those communities in low-income countries.

Convinced of the benefits of workforce diversity he actively supported and promoted ANZCA's Gender Equity Position Statement during his presidency. In mid-2019 he visited Papua New Guinea to represent ANZCA at the PNG Society of Anaesthetists' annual conference in Port Moresby.

Rod's presidency ended in May 2020 as the world grappled with the first wave of the global COVID-19 pandemic. He played a key role in collaborating with other Australian and New Zealand medical specialty colleges to highlight the urgency of supplying frontline health workers with personal protective equipment and the need to suspend elective surgery to limit the spread of the virus.

He was the founding chair of ANZCA's Indigenous Health Committee from 2010 to 2015 and remained a member of the committee until this year. He has also been an avid supporter of the college's development of perioperative medicine and ANZCA's role of providing leadership and co-ordination with other stakeholders to progress the recognition and qualification of the multidisciplinary specialty.

Rod was keenly aware of the critical importance of not only maintaining, but strengthening the college's external partnerships, including in the world of research and ANZCA's Clinical Trials Network. He recognised the value of successful partnerships and joint ventures with other colleges and external stakeholders in education, examinations and research.

He was also committed to enhancing the college's multidisciplinary collaboration, and the mutual benefit of anaesthesia and pain medicine working together under the banner of one college.

ASSOCIATE PROFESSOR MICHAEL VAGG (FPM DEAN)

Associate Professor Vagg is a specialist pain medicine physician and a consultant in rehabilitation and pain medicine. He graduated from Monash University in 1994 and spent several years as a uniformed medical officer in the Royal Australian Air Force before undertaking vocational training.

He has been an FPM Board member since 2013 and is a former vice-dean of the faculty. His areas of clinical interest include soft tissue pain, postamputation pain and interventional pain treatments.

Despite the ongoing challenges of the COVID-19 pandemic his leadership of the faculty helped strengthen the development of professional pain medicine practice education, training and advocacy during a tumultuous period.

During his term as dean he worked with ANZCA colleagues to create the new Director of Professional Affairs education role which will enable the faculty to refresh and maintain its world-leading training program. He also drove the development and implementation of the Procedures Endorsement Program to provide training in pain medicine procedures and led the creation of clinical care standards.

Mick was a committed advocate for the faculty pursuing stronger government engagement at the state and federal level to not only raise the faculty's profile but pushing for better access and funding of pain services across Australia and New Zealand.

Mick is serving another two years on the FPM Board and will provide ongoing leadership for the faculty as the Chair of the Procedures Endorsement Program.

DR NIGEL ROBERTSON

Dr Robertson is a specialist anaesthetist at Auckland City Hospital. He is a former clinical director (head of department) and is now the director of Perioperative Services at Auckland District Health Board. His clinical interests are in neuroanaesthesia and neuro-interventional radiology and he is a former tutor on the local final exam course. He has a long-established interest in operating room efficiency and hospital system development and redesign, having been a member of the building team for Auckland City Hospital.

He was first elected to ANZCA Council in 2016 and served two terms before deciding not to seek re-election in 2022 to pursue a better work/life balance. He is a former chair of the New Zealand National Committee and is the chair of ANZCA's Professional Affairs Executive Committee. He has also chaired the Safety and Quality Committee and the Continuing Professional Development Committee.

He is a key member of the group developing practice standards for the delivery of safe procedural sedation across the health sector in Australasia. He was also a contributor to the revision of the continuing professional development requirements for practice recertification in New Zealand and Australia. In the early phase of the COVID pandemic, he chaired the Clinical Expert Advisory Group charged with developing the college position on personal protective equipment and other measures to respond to the crisis.

DR SEAN MCMANUS

Dr McManus completed three years of rural generalist training before undergoing specialty training in anaesthesia, gaining his FANZCA in 2003. He worked as a consultant anaesthetist for 10 years, before formalising his intensive care specialty training and becoming a fellow of the College of Intensive Care Medicine in 2015.

He worked in Far North Queensland for more than 20 years, joining ANZCA's Queensland Regional Committee in 2007 and becoming chair in 2012.

He served on the ANZCA Council from 2014 and served as honorary treasurer from 2018 to 2020. He is continuing as chair of the Indigenous Health Committee and chair of the Perioperative Medicine Steering Committee. He has been a member of several committees, including Continuing Professional Development Committee and Education Executive Management Committee.

He is passionate about improving patient care through the ANZCA perioperative medicine project and bringing anaesthetists, intensivists and physicians together to improve care for high risk/reward surgery. His work with the Indigenous Health Committee has been shaped by his determination to improve healthcare outcomes for Indigenous and Māori communities.

He is an experienced assessor of specialist international medical graduates (SIMGs) and an accreditation inspector for the Training and Assessment Committee.

Introducing our new councillors

There are five new members of ANZCA Council following an election earlier this year.

DR SALLY URE

Dr Ure is the immediate past chair of the New Zealand National Committee (NZNC) and is passionate about the provision of quality healthcare to our patients, addressing inequity in health outcomes, and practitioner wellbeing.

Her extensive educational and leadership experience has developed through a range of varied roles involving training and accreditation, advocacy and policy for the college.

She was appointed as a co-opted member of the NZNC in 2011 and became a member in 2012. Her leadership roles have included NZNC deputy chair (2017 to 2020), Training Accreditation Committee (TAC) accreditation officer (NZ) and chair of the Education Officer Network (2014 to 2017) while acting/deputy education officer for New Zealand.

She has been Clinical Director, Department of Anaesthesia, Wellington Hospital since 2018, and prior to that was deputy director for five years.

DR MARYANN TURNER

Dr Turner was the new fellow councillor on ANZCA Council from 2020 to 2022 and is a member of the Safety and Quality Committee. She has fellowship experience at London's Great Ormond Street Hospital, Auckland's Starship Hospital, and Queensland Children's Hospital.

Her longstanding interest in advocacy, wellbeing and research led to her co-chairing the 2017 ANZCA Trainee Committee, co-establishing Australia's first anaesthesia trainee-led research network and engagement with multiple ANZCA committees, working groups and special interest group executives.

Before becoming an anaesthetist, she was admitted as a lawyer of the NSW Supreme Court; completed a masters in medical law; and worked in corporate and criminal law.

Her other ANZCA committee and working group roles include chair of the Awards Review Working Group (2020 to 2021), and membership of the Emerging Investigators Subcommittee, Trainee Bursary Evaluation Subcommittee and Standards Project Working Group.

DR BRIDGET EFFENEY (CO-OPTED)

Dr Effeney is a specialist anaesthetist in private practice in Brisbane who achieved fellowship in 2011. Her specialty areas include neuroanaesthesia.

She trained in Cairns and Brisbane and has contributed broadly to ANZCA in events, professional affairs and gender equity. She was convenor of the ANZCA Annual Scientific Meeting (ASM) in 2017 and has been a member of the Professional Affairs Executive Committee since 2018.

She has also been a member of the ASM and Events Planning Committee since 2015 and chair of the Gender Equity Sub-Committee since 2019.

DR KATHERINE GOUGH (NEW FELLOW COUNCILLOR)

Dr Gough recently completed training at Royal Prince Alfred Hospital and is a visiting medical officer at Royal Prince Alfred, Chris O'Brien Lifehouse, Westmead and Hornsby Hospitals in Sydney.

Her interest in wellbeing, equity and education has been highlighted by her involvement with ANZCA as a trainee through multiple committees and working groups. As co-chair of the ANZCA Trainee Committee in 2020 she had first-hand experience working with the college to mitigate the impact of the COVID-19 pandemic on training and the workforce.

As New Fellow Councillor she will be a dedicated advocate, continuing to work with ANZCA to promote equity and opportunity for new fellows in the Australian and New Zealand anaesthesia workforce.

DR KIERAN DAVIS (FPM DEAN)

Dr Davis works as a specialist pain medicine physician and anaesthetist at Auckland City Hospital. He has held key faculty positions including vice-dean, founding chair of the FPM New Zealand National Committee, and has chaired both the FPM Examinations Committee, FPM Training and Assessment Executive Committee and the Training Unit Accreditation Committee.

He is a graduate of Leeds University and trained in anaesthesia in the north-west of England before undertaking further studies in pain medicine in Auckland. He was the clinical director of the Auckland Regional Pain Service from 2005-2017.

Dr Davis believes the one in five Australians and New Zealanders who suffer from chronic pain should have better access to quality services.

ANZCA Council appointments

At the ANZCA New Council Meeting held on 2 May, Associate Professor Deborah Wilson was appointed honorary treasurer, Associate Professor Jo Sutherland to the chair of the ANZCA Safety and Quality Committee and Dr Scott Ma was elected as the ANZCA councillor on the FPM Board. Following is a list of individual appointments and chairs of committees reporting to ANZCA Council.

For a full list of committees visit anzca.edu.au/about-us/our-people-and-structure

Honorary treasurer	Associate Professor Deb Wilson
Chair of examinations	Dr Mick Jones
Councillor on FPM Board	Dr Scott Ma
Medical editor	Dr Tanya Selak
Honorary curator	Dr Christine Ball
Honorary historian	Professor Barry Baker
Safety and Quality Committee chair	Associate Professor Joanna Sutherland
Professional Affairs Executive Committee chair	Dr Nigel Robertson
Perioperative Medicine Steering Committee chair	Dr Sean McManus
Education Executive Management Committee chair	Associate Professor Leonie Watterson
Training Accreditation Committee chair	Dr Mark Young
ANZCA Research Committee chair	Professor David A Scott
ANZCA Foundation Committee chair	Dr Rod Mitchell
Finance, Audit and Risk Management Committee chair	Mr Richard Garvey
Information and Communications Technology (ICT) Governance Committee chair	Associate Professor Stuart Marshall

Note: Ex-officio ANZCA Trainee Committee representatives on committees: Dr Harsh Dubey and Dr Alec Beresford

Australian regional and New Zealand committees

Elected national and regional committees act as a conduit between fellows and trainees in the regions and the ANZCA Council to which they report. The committees assist with:

- Implementing college policy in their regions.
- Advising ANZCA Council on issues of interest to the college and its fellows and trainees in the regions.
- Representing the college and promoting the specialty in the regions.
- Developing and maintaining relationships with key regional stakeholders.
- Training, continuing medical education, and other professional activities at a regional level.

New Zealand National Committee Chair	Dr Graham Roper
ACT Regional Committee Chair	Dr Natalie Marshall
NSW Regional Committee Chair	Associate Professor Nicole Phillips
Queensland Regional Committee Chair	Dr Paul Lee-Archer
SA and NT Regional Committee Chair	Dr Nagesh Nanjappa
Victoria Regional Committee Chair	Dr Nam Le
Tasmania Regional Committee Chair	Dr Lia Freestone
WA Regional Committee Chair	Dr Marlene Johnson

ANZCA and FPM media coverage

Highlights since the Autumn *ANZCA Bulletin* include:

"Connected consciousness study: Why women are baffling anaesthesia experts"

(RADIO 2GB SYDNEY, 25 MAY)

FANZCA Professor Robert Sanders was interviewed on radio 2GB Sydney's afternoon program hosted by Deborah Knight about an international study on connected consciousness. The findings, published in the *British Journal of Anaesthesia*, are the largest international cohort study of its kind, involving 338 participants and 10 hospitals across Australia, Belgium, Germany, Israel, New Zealand, and the US. Professor Sanders, senior study author, is an anaesthetist from the University of Sydney and Royal Prince Alfred Hospital. The 10 minute interview reached an audience of 50,000 people.

"Chronic pain and the postcode lottery"

(RADIO NEW ZEALAND NIGHTS, 9 MAY)

New FPM Dean Dr Kieran Davis told Radio New Zealand *Nights* presenter Bryan Crump he wants to see a more equitable service for the one in five New Zealanders who live with chronic pain. In a wide-ranging 22 minute interview, Dr Davis talked about the Expert Advisory Group's work with the NZ Ministry of Health and his hopes that pain clinics will be integral in the New Zealand health reforms.

"Why do antidepressants help with nerve pain relief?"

(COSMOS MAGAZINE, GEELONG ADVERTISER, 3 MAY)

Immediate past FPM dean, Associate Professor Michael Vagg was interviewed by the *Geelong Advertiser* and *Cosmos* magazine for a 3 May article about new research into pain relief by the CSIRO. Associate Professor Vagg said the new research investigating antidepressants and nerve pain helps open up the possibility of a new class of better drugs. Researchers have shown how tricyclic antidepressants (TCAs) work against nerve pain, also known as neuropathic pain, paving the way for further research and therapies.

"Opioids given the chop"

(CANBERRA TIMES, DAILY TELEGRAPH, 27 APRIL)


Opioids given the chop

Associate Professor Jennifer Stevens, FANZCA and FFPMANZCA, was quoted by Australian Associated Press and News Limited about new standards of care on opioids issued from the Australian Commission on Safety and Quality in Health Care. The 27 April articles quoted Associate Professor Stevens in her role as an anaesthetist and pain management specialist at Sydney's St Vincent's Hospital. The clinical care standard encourages simple analgesics like paracetamol and anti-inflammatories, and non-medication for mild and moderate levels of pain.

A comprehensive media digest can be found in each edition of the monthly *ANZCA E-Newsletter* and on the college website.

ANZCA and government

AUSTRALIA

Federal election sees change of government

A federal election was held in Australia on 21 May which resulted in a Labor government led by Anthony Albanese taking office following nine years of a Liberal National coalition. Australia's new Minister for Health and Aged Care is Mark Butler. The Minister for Indigenous Affairs is Linda Burney.

Peter Dutton is the new leader of the opposition and Sussan Ley is deputy leader (both Mr Dutton and Ms Ley are former ministers of health). David Littleproud replaced Barnaby Joyce as leader of the federal National Party.

In the lead-up to the federal election the college submitted a 2022 election priorities statement to the major political parties. The election priorities statement outlines our priority advocacy areas and invited each party to outline their policy positions in response. The six priority issues are:

1. Perioperative medicine.
2. Improving health outcomes for Aboriginal and Torres Strait Islander Peoples.
3. Improving the management chronic pain.
4. Reducing costs to patients for chronic pain services.
5. Access to health services for regional, rural and remote Australians.
6. Climate change and the creation of a National Climate Change and Health Strategy.

In the coming weeks, the college will make contact with the relevant ministers and looks forward to continuing to work constructively with government on priority matters for anaesthetists and specialist pain medicine physicians.

Health outcomes and access to health and hospital services in rural, regional and remote NSW

The NSW Parliament recently released a report into access to health and hospital services in rural, regional and remote NSW. The report represents the output from a comprehensive consultation process that commenced in August 2020 and received more than 700 submissions and held 15 public hearings. The college and the Faculty of Pain Medicine made separate submissions to the inquiry and faculty board member Dr Susie Lord and faculty NSW regional committee member Professor Paul Wrigley presented as witnesses to the inquiry.

The 22 findings of the inquiry would be of no surprise to healthcare professionals working in rural NSW (see table 1).

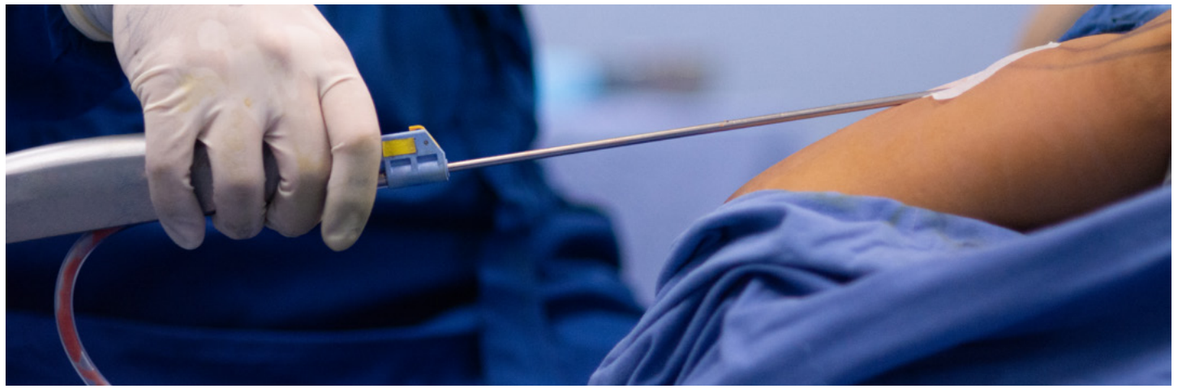
The report lists 44 recommendations to address these findings, some of the key ones being:

- The establishment of a Rural Area Community Controlled Health Organisation pilot for areas where existing rural health services do not meet community needs.
- The development and implementation of a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy.
- Increasing rural GP and specialist training positions through greater collaboration between NSW Health, the Australian government, primary health networks, the university sector and specialist medical colleges.
- The establishment of a palliative care taskforce to plan access and services, establish a uniform state-wide platform for the collection of palliative care data, promote innovative models of service and ensure culturally appropriate services are available.
- Improving the cultural safety of health services by engaging with Aboriginal Elders and local communities, building the Aboriginal workforce and mandating the requirement for each Local Health District to have at least one Aboriginal community representative on the governing board.
- Undertaking an inquiry and report on the progress and developments that have been made to address the matters raised by this inquiry on the two-year anniversary of the report's tabling.

In response, the NSW government recently announced the establishment of a Regional Health Division of NSW Health to focus on improving access to health services and health outcomes for rural and regional NSW communities. For further information on the inquiry visit parliament.nsw.gov.au.

TABLE 1: SUMMARY OF INQUIRY FINDINGS

Inequalities in health access and outcomes	Funding	Workforce	Aboriginal and Torres Strait Islander health	NSW Health and Local Health Districts
Rural patients have significantly poorer health outcomes and inferior access to health services. There is a lack of palliative care and palliative care services in rural NSW.	Medical staff are significantly under resourced, exacerbating health inequities. Many rural and remote hospitals are marginally viable at best under the activity-based funding model.	There is a critical shortage of health professionals across rural, regional and remote communities. There has been a failure by various NSW and Australian governments to attract, support and retain health professionals, especially doctors and nurses, to rural areas.	Aboriginal and Torres Strait Islander patients continue to experience discrimination when seeking medical assistance in some rural NSW hospitals. Telehealth has created another barrier for Aboriginal and Torres Strait Islander patients in terms of accessing culturally appropriate health services.	There is a lack of transparency and accountability in NSW Health and the rural Local Health Districts, a culture of fear operating within NSW Health and a lack of communication and consultation between Local Health Districts and communities.



Cosmetic surgery inquiries

The college made submissions to two recent reviews into cosmetic surgery that were announced in the wake of last year's ABC TV Four Corners program "Cosmetic Cowboys". The Australian Health Practitioner Regulation Agency (Ahpra) reviewed the regulation of health practitioners in cosmetic surgery and the Health Ministers' Meeting (formerly the COAG Health Council) examined the use of the title of *surgeon* by medical practitioners in the Health Practitioners Regulation National Law.

Our response to both inquiries highlighted the college's position that the title surgeon should be reserved for use by those who have undertaken specialist training in surgery.

It was also highlighted that cosmetic surgical procedures commonly employ sedation and analgesia provided by anaesthetists as well as by a range of other medical and health practitioners with diverse qualifications and training. Practitioners providing anaesthesia, sedation or analgesia as part of a cosmetic surgical procedure must be appropriately qualified and trained. The college's professional documents seek to promote uniform standards for high quality and safety in the administration of local anaesthesia, major regional anaesthesia, analgesia administered without sedation, general anaesthesia, and procedural sedation by all duly qualified health practitioners in Australia and New Zealand.

Ahpra also sought feedback on mandatory and voluntary reporting obligations. Anaesthetists' limited exposure to cosmetic surgery can lead to uncertainty around the appropriateness of observed practice and the college made suggestions to increase transparency. These include mandatory reporting of complication rates, referencing patient baseline risk to make comparisons valid and guidelines for quality practice for all cosmetic medical procedures.

Finally, the college submissions to both of these inquiries made reference to the development of a collaborative model of perioperative medicine. For all surgery, including cosmetic surgery, the impact of comorbidities and chronic conditions on surgical outcomes highlights the important role multidisciplinary teams can play in preoperative shared decision making and co-ordination of perioperative care from initial surgical assessment and preoperative optimisation through to postoperative follow up, including ongoing specialist and primary care. An emphasis on perioperative medicine enables practitioners to work collaboratively to optimise management of patients at high risk, including those seeking cosmetic surgical procedures.

ANZCA endorses liposuction guideline

In August 2021 an expert working group including ANZCA Vice President, Professor David Story, was established by the Victorian Department of Health's Private Hospitals and Non-Emergency Patient Transport Regulation Branch to produce an evidence-based guideline for liposuction. A draft was released for stakeholder consultation in February 2022, which was referred to ANZCA's Safety and Quality Committee for comment.

The committee provided some feedback relating to scope – namely, that tumescent anaesthesia and analgesia techniques used for liposuction should not be assumed to be safe for other procedures, as the body location of the procedure and characteristics of the patient group will differ. This feedback was accepted by the department in full.

The *Guideline for providers of liposuction: Best practice guideline for clinicians and those involved in the provision of liposuction* is for all providers of liposuction in Victoria, regardless of whether the procedure takes place in hospital, a registered day procedure centre or a medical practitioner's rooms. Topics covered include patient admission criteria, patient assessment, informed consent and shared decision-making, credentialling, facilities and equipment, the procedure itself, discharge and follow-up care, reporting, complaints, and more. This guideline complements the college's recent advocacy on cosmetic surgery regulation at the Australian national level.

NEW ZEALAND

Budget update

The Minister of Finance, Grant Robertson, delivered the 2022 New Zealand budget on 19 May. The health vote removed any doubt about the much-needed funding of health services across New Zealand with a record $11.1 billion dollars committed to health spending. The ongoing annual funding boost for the new Health New Zealand (HNZ) of $1.8 billion in year one, plus $1.3 billion in year two made up a significant part of this record-setting amount. This is also the first moved towards a bi-annual funding cycle.

As part of the 1 July health reforms to the overall health systems there was $550 million provided to clear the district health board deficits. An additional $300 million will be provided as part of these health system changes to operating and capital expenses specifically for data and digital infrastructure.

There is recognition that Māori health needs strengthening with a commitment of $299 million. The new Māori Health Authority has received $168 million over the next four years with many commentators noting that equity still will not be reached considering the multibillion-dollar operating budget HNZ has received.

Although a large amount of money has been earmarked for capital improvements there will not be an immediate impact on hospital waiting lists. This problem pre-dates the pandemic and has prompted the government to create a high-powered taskforce led by Counties Manukau chief medical officer Dr Andrew Connolly. In a recent meeting with the Council of Medical Colleges, Dr Connolly noted that not only money but human resources have been committed to addressing issues that are creating unacceptable waiting lists. This will be a priority for HNZ.

PHARMAC, New Zealand's drug buying agency, has received an extra $191 million of funding over the next two years. A recent review into PHARMAC showed the agency contributed to inequitable health outcomes for Māori, Pasifika, and people with rare disorders. With the government accepting nearly all the 33 recommendations provided by the review panel. There will be an increased focus on equity and more effective purchasing of a wider range of drugs.

SUBMISSIONS

The college prepares submissions and makes representations to government and other stakeholders on a range of policy initiatives and inquiries, many of these in response to requests for college feedback and input. Our submissions to public inquiries are available on the college website following the inquiry closing date. Note that some inquiries and requests for college input are confidential. For a listing of recent submissions visit www.anzca.edu.au/safety-advocacy/advocacy..

Australia

- Australian Commission on Safety and Quality in Health Care: Stillbirth clinical care standard.
- Australian Health Practitioner Regulation Agency: Review of the regulation of health practitioners in cosmetic surgery
- Australian Medical Council: Proposed criteria for AMC accreditation of CPD homes.
- Health Ministers' Meeting: Use of the title 'surgeon' by medical practitioners in the Health Practitioner Regulation National Law.
- University of Sydney: Evidence-based clinical practice guidelines for deprescribing opioid analgesics.

What would you do?

Dr Peter Roessler explains ANZCA's professional documents using practical examples. In this edition he explores effective and caring communication.

IN THIS EDITION, the following scenario is somewhat different from previous ones with the intention of furthering an appreciation of the value that anaesthetists, pain medicine specialists and perioperative medicine specialists can contribute.

SCENARIO

You are faced with a patient who is proposing to present for anaesthesia (for a surgical/interventional pain procedure) and is seeking assistance with access to information regarding an experience under anaesthesia during childhood several decades ago, where they describe having had an "out-of-body" experience.

They firmly believe that they had died and described the event as most pleasant and recall that they had not wished to "return back into their body". They have since had several procedures uneventfully under general anaesthesia and regional anaesthesia and reaffirm that they have no fears with regard to general anaesthesia, and simply want to know what happened.

WHAT WOULD YOU DO?

Needless to say, after more than 25 years, the records would no longer be available. How would you help this person and how would you advise them?

In considering these questions it is easy to focus on the presenting request for access to their record and dismiss the matter by concluding that the records have been destroyed. However, in doing so, is it possible that we may be missing their real underlying problem?

On pursuing the reason for their request, it became apparent that what they really wanted was confirmation that they had in fact died and wanted to know for how long they had been "dead". Having a copy of the record would serve to confirm their belief that they had died.

On further questioning it became evident that they felt the need to convince their family that the experience was real and that they had returned from the dead. They needed to prove a point to their loved ones, who clearly doubted and discredited the account. This appeared to be important in the context of their cultural background.

The elephant in the room was why at the time of the experience, they had not wanted to return to life and why this had bothered them for so many years. What childhood issues were there and are they currently suffering some mental illness, for which they need help?

We are not psychologists nor psychiatrists and clearly should not be counselling patients on such issues. Given the college's mission to serve the community by fostering safety and high-quality patient care and in the context of perioperative medicine with optimisation of patient physical and mental wellbeing how do our professional documents stack up in this setting?

While the guideline *PG07(A)* on the pre-anaesthesia consultation provides recommendations intended to ensure that patients are adequately assessed and prepared, it does not include consideration of patient wellbeing and mental state – a gap that may need to be considered in a future revision if thought to be significant. Similarly, the position statement PS26(A) on informed consent addresses capacity for consent, however, it is silent on certain mental health issues such as depression.

The guideline *PG49(G)* on wellbeing is intended to assist doctors with health and wellbeing related issues. Some of the principles and advice contained in this document can readily be applied to anyone with whom we come into contact. Of the suggestions offered in the Wellbeing Special Interest Group document RD03(2016), many apply equally well to doctors as well as the general community. The helpful list at the end, of "who you can call on" (no, not Ghostbusters) includes suggestions applicable to the general community.

After establishing rapport and trust with patients in a culturally sensitive fashion, they are more likely to feel safe to divulge relevant personal information and be receptive to any suggestions or recommendations offered to them with regard to seeking assistance. *PG62(G)* on cultural competence provides guidance that promotes the ability for effective communication in this context.

In the perioperative medicine setting, the revelation of possibly significant underlying problems that may either influence or outlast the physical effects of surgery and anaesthesia aligns with the college's mission and our goals as specialists caring for our patients.

It is at times intriguing what can be uncovered when scratching away at the surface only to find what lurks beneath.

Dr Peter Roessler
Director of Professional Affairs, Professional Documents

Perioperative medicine

Diploma continues to take shape

SIGNIFICANT PROGRESS HAS been made on the development of our diploma in perioperative medicine (DipPOM) with our model of delivery now clearly outlined and endorsed by the Perioperative Medicine Steering Committee and ANZCA Council, along with our timeline for rolling out the diploma.

Our newly established POM Content and Assessment Working Group chaired by Dr Joel Symons is developing the DipPOM Curriculum Framework which outlines the aims and learning outcomes of the diploma.

The framework also describes our model o f delivery (which will be via a combination of online content, in person workshops and learning in the hospital setting) as well as our target audience and entry criteria, our approach to assessment, teaching and learning activities and the facilitation structure and approach.

Learning outcomes have been established for the six topic areas of the diploma:

- **Perioperative assessment** which includes surgical review and risk assessment.
- **Preoperative planning** which involves the decision on whether to pursue operative intervention.
- **Optimisation** including a pre-procedure review.
- **Intraoperative impacts on patient outcomes**.
- **Postoperative assessment and management** including an assessment of the post-procedure disposition and care and safe recovery in the postoperative period.
- **Discharge planning and rehabilitation** which covers safe recovery and handover to the primary referrer/carer with appropriate follow-up.

Each topic area closely aligns to the Perioperative Care Framework, which was developed by the POM Care Working Group chaired by Dr Jeremy Fernando and approved late last year.

Teaching and learning activities will include interactive facilitated workshops, supervised clinical activities, webinars, online groups to foster engagement and networking, case studies, reading lists, videos and lists of relevant courses and resources.

Assessments will be through a combination of online tasks, case-based discussions, short-answer questions and workplace-based assessments.

The selection and training of assessors through the now-defined grandparenting process will occur in coming months. Our grandparented diploma holders will be those practitioners who will receive the diploma based on their experience and past involvement in perioperative medicine.

Recognition of prior learning is also being developed and this will guide applicants on which topic areas they will need to complete and which ones they need not complete.

The diploma will be delivered by:

- **Topic area leads** who oversee participant progression for each module and ensure all assessments are completed/undertaken.
- **Facilitators**, who support delivery of teaching and learning activities through workshops and online.
- **Clinical supervisors** who oversee the participant in the clinical learning environment and complete workplace-based assessments.

Recognition of prior learning guidelines will be developed in time for the first candidates to apply next year and begin the course in the final quarter of 2023.

While this work is being done, our advocacy work continues.

We are continuing to promote the diploma to potential candidates – anaesthetists, intensivists, surgeons, physicians (geriatricians, internal medicine, rehabilitation) and GPs (including rural and remote doctors). The entry criteria for potential participants will be part of the DipPOM Curriculum Framework.

We are also working on promoting the merits of the perioperative medicine model to governments (national and regional), to public and private hospitals and eventually to insurers.

Critical to this is the development of a "value proposition" where the economic advantages of perioperative medicine will be articulated.

I chair the new POM Economics Working Group and Professor Guy Ludbrook is my deputy. We are developing a comprehensive brief to guide consultants to undertake an independent analysis of the value of a perioperative care model that will demonstrate and defend the case for resource allocation.

The ANZCA Library is also working with the Professor Ludbrook to update the 2018 and 2019 literature reviews already undertaken by the college.

Discussions are also under way to review ANZCA's professional documents to ascertain what needs updating and whether new ones might be required.

The college is also exploring the development of continuing professional development pathways for diploma holders.

Discussions are well under way regarding the technical solutions for a delivery platform and other operational requirements such as establishing fees (to be finalised in 2023) and what resourcing requirements at ANZCA will be required in an ongoing basis.

Dr Sean McManus
Chair, Perioperative Medicine Steering Committee

Topic area	12 months								
	Trimester 1 (10 wks)			Trimester 2 (10 wks)			Trimester 3 (10 wks)		
1. Preoperative assessment	Block 1	Block 2	Block 3						
2. Preoperative planning	Block 1	Block 2	Block 3						
3. Optimisation				Block 1	Block 2	Block 3			
4. Intraoperative impacts on patient outcomes				Block 1	Block 2	Block 3			
5. Postoperative Assessment and Management							Block 1	Block 2	Block 3
6. Discharge planning & rehabilitation							Block 1	Block 2	Block 3

The anaesthesia nurse consultant:

Navigating through perioperative care

Austin Health has committed to including "nurse navigators" who help guide surgical patients through the system.

THE EARLY EVOLUTION of the anaesthesia nurse consultant role in the Department of Anaesthesia at Austin Health began in 2007.

This unique service started due to needs that were identified in the anaesthesia pre-admission clinic (APAC). It was recognised that structure, continuity, and coordination was needed for complex patients who were presenting in the APAC, often with scattered or incomplete data.

Initially, this co-ordinated approach to improve perioperative care was left to a single anaesthesia consultant. While enthusiastic and invaluable, they were expected to make decisions with missing information, conduct a full assessment of a patient, consent them for anaesthesia mode and help facilitate further testing requirements. Sometimes there would be eight patients, sometimes 11, each with varying needs.

Caroline Hasdo

In addition, other patients would present on the day of surgery without attending the APAC. The strong view of anaesthetists was that patients would benefit from a review in this clinic and that there was a missed opportunity to optimise their unstable medical conditions that were not identified prior to the day of surgery and improve communication and the exchange of information between the anaesthesia team and the surgical units.

Equally, the gaps in pre-admission care become discernible because some patients would present to these clinics without a compelling need for a review. Indeed, there were inefficiencies, and work needed to be undertaken to improve the journey to surgery.

The proposal for an anaesthesia nurse liaison or navigator role came from both motivated anaesthesia nurses and a few consultants within the department. The benchmarking research came from overseas centres in New York, Pennsylvania, and Atlanta, reviewing models from the nurse practitioners in the preoperative setting through to advanced practice nurses serving as a diagnostic filter for the anaesthetists.

In the available literature, the outcomes included a reduction in day-of-surgery cancellations and delays, and conveyed the nurses as navigators, implementing processes and policies and improving a quality-based, cost-effective alternative to additional physician resourcing for preoperative care. At the time, there was no such role in a major Australian public hospital.

Day-of-surgery cancellation prevalence was the biggest driver of change in this space during that time. The inefficiencies, costs and resources associated with day-of-surgery cancellations, and the additional burden on waitlists (in an already exhausted area of public health), provoked visions for efficiency. At the time of the proposal in 2008, it was predicted that 20 per cent of all cancellations could have been preventable with appropriate preoperative management. After a 12-month trial, the preventable day-of-surgery cancellation statistics fell to under 5 per cent, with current cancellation figures at less than 1 per cent.

Additional data to justify this role to date include an increase in referral and clinic capacity; resourcing and support for surgical units; a reduction in wait times for the patients' journey from consent time to being deemed medically ready for care; and staff and patient satisfaction. After a couple of years, this role was permanently supported by the hospital, where funding is regularly allocated to the unit. This role is recognised as a fundamental resource with respect to surgical activity.

Over the past 14 years, the role has evolved organically to meet the demands in elective surgery.

Professor Laurence Weinberg with Shaylene Deakin.

"It was predicted that 20 per cent of all cancellations could have been preventable with appropriate preoperative management."

Initial staffing and branding of the service were the fastest elements to grow, as these provided a much-needed support avenue for junior medical staff. This has grown to an email inquiry service, with a direct phone line for all staff across the hospital who need generalised direction and assistance (this can include a review of complex tests, and it could be as general as advice with medication management).

Every few years, there is a clinic and capacity increase based on the ever-increasing volume of elective surgery work and growing patient complexity. Further specialist clinics have been introduced, initially with the aim to cater for patient groups such as high perioperative risk patients.

A co-working space between the anaesthesia, geriatric and general medicine physicians has been successful in enabling shared decision-making and collaboration. And with growing interest over the last year, there has been an introduction of our nurse presence to the emergency surgery patient group.

The group of nursing staff is carefully selected and developed over time, and their characterises are strikingly similar: a thirst for development; the ability to easily establish relationships and bridge communication; and a focus on improving the systems.

The nurse workload vision is prepared so that all staff have opportunities in the aspects mentioned above: clinical assessments for elective surgery patients, inpatient reviews, collaborative meetings, inquiry and resource assistance, presenting to other executive or nursing groups and representing the perioperative care team where required. In addition to this, the team works clinical shifts within the recovery and anaesthesia departments, not only providing them with up-to-date anaesthesia and recovery techniques to aid in consenting patients but also acting as a senior presence to other clinical or ward staff.

While hospital endorsement and executive feedback helped support the permanent funding and implementation of the role, the support of the entire medical anaesthesia group was crucial to its success and for its continual growth to date. The support came in many ways and included (and still includes) ad hoc education; involvement in medical education (a privilege not many nurses receive while they are on the job); active involvement in complex decision-making; opportunities to represent the unit with various stakeholders and committees; undertaking research, process and policy redesign; and involvement in incident reviews and quality projects.

Some honourable mentions to our patrons: Shaylene Deakin (the original nurse pioneer) and Dr Peter McCall (head of cardiac anaesthesia at the Austin and our first strong advocate in the early years), Professor David Story (Foundation Chair of Anaesthesia at the University of Melbourne and the mover-and-shaker for our team), Professor Laurence Weinberg (the current director of anaesthesia at the Austin and our resident motivator), and Dr Ranjan Guha and Dr Justin Nazareth (co-leads of perioperative medicine at the Austin) who have helped lead and have directed the vision of our perioperative care team.

The looming problems of the growing surgical waitlists, the complexity of patient demographics, and resource pooling over the last couple of years have highlighted significant gaps in our ability to provide the best possible care. While traditional solutions would include funding to provide the minimal care requirements, perhaps a more sustainable approach is needed: the future of filling these gaps.

Caroline Hasdo
Anaesthesia Clinical Nurse Consultant, Perioperative Care Team
Austin Health

Venessa's choice

NSW recently became the final state in Australia to pass voluntary assisted dying (VAD) laws. Sydney fellow Dr Gavin Pattullo gives a very personal account of his experiences with VAD following the death of his wife Venessa.

I LOOK AT the time; 4.13 in the morning when I hit send on my email to the *Sydney Morning Herald* (SMH). I am scared. Scared because I am about to let a dark secret out. I am also a little sad. The sadness that can only come from being reminded of the loss of your soul mate, that of my wife Venessa. Overwhelmingly though I am happy. Happy because Venessa is going to have her voice back and be heard as she deserves.

So started my unplanned entry into the debate on voluntary assisted dying (VAD) as the bill was entering debate in the NSW parliament lower house.

Three years prior, Venessa had ended her life alone and without telling a soul of her plans. It was a Monday afternoon and I had gone off to work like any other day. I should have known something wasn't right. As I left home Venessa gave me a tight hug – longer than usual – and tears were welling up in her eyes.

Aged only 42 and after 14 years of living with aggressive acute leukaemia Venessa had never given up. Countless horrific procedures she had undergone pushing her body to the limits of survival. Chemotherapy, repeated neutropenia's, painful mucositis, whole body irradiation, bone marrow transplants, lumbar punctures, central lines, PIC lines, MRIs, CT scans, lung function tests, blood tests, blood product transfusions. Unrelenting for 14 years.

Anorexia and malabsorption left her at only 41 kilograms – from a much healthier number she would be angry about me stating here. Then, cruelly, graft versus host disease destroyed her lungs. Reliant on an oxygen concentrator to allow her to do many of her ADLs, reliant on me to propel her in a wheelchair if she wanted to "stroll" with me along our happy place of Sydney's Balmoral Beach Promenade.

"Aged only 42 and after 14 years of living with aggressive acute leukaemia Venessa had never given up."

Knocked back for a lung transplant, a slow death by hypoxaemia awaited her. Venessa hadn't been beaten, she hadn't lost her battle. It is not a fight and it is not a war. Forget the emotive victim cliches. It is just life. The cards you are dealt when you are born, I would tell Venessa so many times over the years. Venessa took control of her delivery into death. She said when, where and how.

An accomplished doctor, gastroenterologist with a PhD in hepatology, a career spent working in hospitals. It is telling Venessa chose to avoid a medicalised palliated death in a hospital, even though that meant dying silently alone at home. Silenced from telling anyone because of the lack of VAD laws in NSW. No proper goodbye to her loved ones, no stories recounted to loved ones for them to cherish, no mutual "I love you". No one holding her hand in the moment when she needed it the most. Alone and in silence. Loved ones left behind imagining how she felt? Was she scared? What was she thinking as she put on her prettiest dress, scented herself with her favourite perfume and lay her head down for the last time in our bed? Was she crying?

Loved ones left behind despising themselves for inexcusably missing the signs, the longing hug and the tears in my case. Loved ones left behind forced to stay silent for fear of the criminal repercussions of a misconstrued implication in her death. Too fearful to check in with a medical professional and relying instead on trusted friends and family. The lies I told; I never did have the heart to tell Venessa's father what happened.

All this was in my mind as I sat facing my computer for hours prior to 4.13am. Fingers firmly jamming letters into the keyboard and yet somehow seemingly comprehensible salient words appearing on the screen before me. I was fired up. Angered by an unbalanced opinion piece in that day's SMH. The author had not lived through the experience of the devastation wrecked by the lack of VADs laws – as we had. The author had the temerity to suggest pain specialists like myself or palliative care could cure all suffering at the end of life. So a buggered set of lungs could be miraculously fixed and a bucolic world existed for all right to the end.

My opinion piece appeared in the next day's edition of the SMH. It went live online at 5am and I woke up at 4.45am in a panic. What the hell have you done, I thought? Why couldn't you just stay quiet? I reminded myself it was no longer about me – it was about all the Venessas in the world. So nervous I couldn't look at any of the online comments myself and had to ask my best friend to look at all the comments first. "Oh, they're all supportive", I was gleefully told. I wearily looked for myself; I saw posted stories of similar experiences, notes of thanks, then private emails appeared from senior doctors I had long admired thanking me for speaking up. And I saw the dark side: trolled on other platforms, even by doctors, friends distanced themselves. Again, I reminded myself it was for Venessa.

Gavin Pattullo (top) and his wife Venessa Pattullo (above left and above)

That was eight months ago and now we are celebrating the passing of VAD laws in NSW.

And yes, we are celebrating. That might seem odd to the reader, isn't death a sad time after all? So why be happy? We are happy because if there is only one less story in the world like Venessa's that is a success for humanity, for compassion, for love, for freedom of choice, for letting people take control of their lives, for allowing people to grieve properly.

Family members who experience VAD for a loved one frequently fare better psychologically than when the alternative transpires[1]. As I campaigned, I heard too many stories like Venessa's. Loved ones sent away on the auspices of a holiday so the dying could end their lives safely for their loved ones. Horrific stories of "home remedy" assisted deaths. Too many tears, too many broken souls, too broken to talk, only the few left to speak up.

"Venessa took control of her delivery into death. She said when, where and how."

And I was buoyed; buoyed by caring politicians determined to make positive change. I met members of the VAD campaigning charities (Go Gentle and Dying with Dignity) all had their own story and all so positive. Andrew Denton, founding director of Go Gentle, even came to my house, drank tea with me and ate my imperfect home-made madeira cake. We shared stories like we had known each other since we were kids. Actually, I could not get the bugger to shut up and had to guide him out of the house (sorry Andrew if you are reading this). Humans united in their grief at what they had experienced.

All states in Australia have passed VAD laws now. Victoria and WA have commenced practice, next will be SA, Queensland, and Tasmania. The territories may take a while more. Australia joins New Zealand (determined by a binding referendum), Canada, Switzerland, Belgium, Germany, Austria, the Netherlands, Spain, and some US states, notably the pioneering state of Oregon, in allowing VAD in its various forms to be provided. Debate is under way in the UK.

VAD laws bring a lot of questions. First terminology needs clarifying. VAD is not suicide. Suicide is always to be prevented. Suicide is the premature ending of one's life when that would not have occurred imminently from a physical process. VAD is for people who are expected to die from a physical illness; in Australia for cancer (the majority of requests) it is within six months (except Queensland – 12 months), or a neurodegenerative disease within 12 months.

Euthanasia is the term in use in many countries, particularly European. In other countries societal attitudes can negatively connotate this term with passivity and lack of decision making. Australia hence saw the introduction of VAD as the preferred terminology, while in Canada Medical Assistance in Dying (MAiD) was chosen.

The disease process is the cause of death in VAD such that VAD does not increase the death rate and it is incorrect therefore to slight VAD as "killing". VAD ensures the process is entirely voluntary including by stipulating patients must make a request for VAD to a doctor on three occasions over many days.

Once determined eligible for self-administration, the doctor writes a script for the medication, the patient receives the medication, stores it securely and finally it is the patient who then self-administers the medication. At any point the patient may halt the process and if they lose decision-making capacity the process stops and usual care ensues. So we prefer and promote the term of VAD for these reasons.

It is not possible for VAD to be provided to someone who does not want it. Two independent specially trained doctors assessing the patient must both determine the patient meets the strict VAD eligibility criteria, is acting of their own free will, understands the repercussions and alternatives of their decision, and has the capacity to make decisions for themselves with regards to end-of-life care. Penalties for doctors not complying with all these requirements are harsh.

Most VAD deliveries so far in Australia have been oral self-administration, in Victoria in the first two years (2019-2021) it was over 80 per cent. The remainder are practitioner IV administrations and these can only proceed with a competent patient request just prior to administration. VAD is highly regulated with all VAD cases reported to a state VAD review board as well as being notified to the coroner.

I have in my career performed terminal sedations on palliative patients in extreme pain under the protection of the double effect doctrine, I worked out how Venessa assisted her own delivery into death and I am aware of the process of oral and IV VAD. Am I convinced Venessa would have been compassionately cared for under VAD Laws and processes? Yes. Only Venessa was not given that option. That wrong has now been righted.

RIP our beautiful girl.

Dr Gavin Pattullo, FANZCA FFPMANZCA
Clinical senior lecturer, University of Sydney

Reference:

1. Swarte NB, van der Lee ML, van der Bom JG, van den Bout J, Heintz AP. Effects of euthanasia on the bereaved family and friends: a cross sectional study. BMJ. 2003;327(7408):189. doi: 10.1136/bmj.327.7408.189

Voluntary assisted dying: ANZCA's stance

IN RECENT YEARS, voluntary assisted dying legislation has been passed in all Australian states and New Zealand. Similar legislation in the Northern Territory and Australian Capital Territory has been overridden by the Commonwealth government.

The issue of legalised voluntary assisted dying for terminally ill people is important for anaesthetists and specialist pain medicine physicians who may be involved in end-of-life discussions and decisions.

Recognising this, and prior to responding to the Victorian government's voluntary assisted dying discussion paper in 2017, the college sought the views of a wide range of ANZCA committee members, fellows, trainees and specialist international medical graduates. The feedback received helped shape the college's response to this and subsequent voluntary assisted dying consultations in other jurisdictions. The college has made submissions to voluntary assisted dying consultations in New Zealand, New South Wales, Queensland, Victoria and Western Australia.

ANZCA has approached the issue of voluntary assisted dying from the perspective of patient and health advocacy:

- To protect patients' rights and to ensure that patients can exercise these rights.
- To ensure that research into palliative care is not an unintended casualty of the availability of voluntary assisted dying.

The college is also concerned with ensuring that medical practitioners, in particular anaesthetists and specialist pain medicine physicians, are protected appropriately under any voluntary assisted dying legislation and not required to undertake activities which they deem inappropriate or contrary to their personal beliefs or their professional responsibilities towards their patients. Further information can be found in our submissions available at www.anzca.edu.au/safety-advocacy/advocacy.

Some differences exist between the legislation in the various jurisdictions. Victoria, for example, has a strict prohibition on health practitioners initiating a discussion about voluntary assisted dying, whereas WA allows a medical practitioner or nurse practitioner to initiate a discussion about voluntary assisted dying as long as at the same time there is a wider discussion about that person's treatment and palliative care options and likely outcomes.

The Queensland Law Reform Commission (QLRC) recently released a report, *A legal framework for voluntary assisted dying*, setting out a proposed structure for voluntary assisted dying legislation in the state (which has subsequently been legislated). An appendix to this report provides a useful comparative guide to the main provisions of current voluntary assisted dying legislation in Australia and selected overseas jurisdictions.

Anthony Wall
General Manager, Policy

VAD LEGISLATION IN AUSTRALIA AND NEW ZEALAND

Jurisdiction	Legislation	Status
New Zealand	End of Life Choice Act 2019	Came into effect 7 November 2021.
New South Wales	Voluntary Assisted Dying Bill 2021 (NSW)	Expected to commence in November 2023.
Queensland	Voluntary Assisted Dying Act 2021 (Qld)	Expected to commence in January 2023.
South Australia	South Australia Voluntary Assisted Dying Bill 2021	Expected to commence by June 2023.
Tasmania	End-of-Life Choices (Voluntary Assisted Dying) Act 2021 (Tas)	Expected to commence in October 2022.
Victoria	Voluntary Assisted Dying Act 2017 (Vic)	Came into effect 19 June 2019.
Western Australia	Voluntary Assisted Dying Act 2019 (WA)	Came into effect on 1 July 2021.

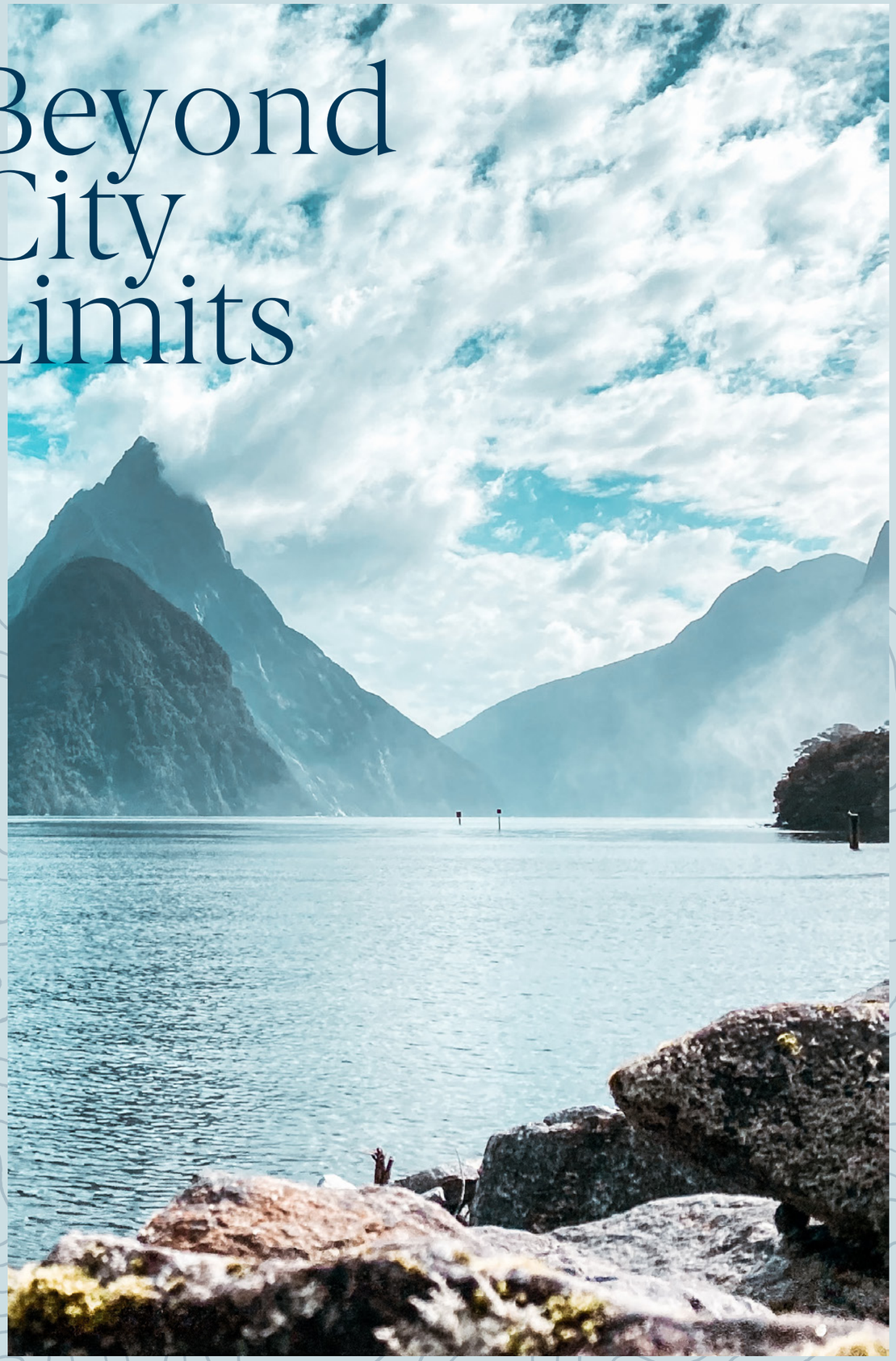
ONLINE VAD RESOURCES

Queensland University of Technology has a range of online resources for clinicians on voluntary assisted dying available at www.end-of-life.qut.edu.au. They also run a free training program for doctors called End of Life Law for Clinicians, covering the law on end of life decision-making more broadly (module 11 is specifically on voluntary assisted dying).

SUPPORT CONTACTS

- Lifeline 13 11 14 www.lifeline.org.au/
- Australasian Doctors' Health Network New Zealand 0800 471 2654
- Dr4Drs 24/7 Crisis Support 1300 374 377 www.drs4drs.com.au/
- ANZCA Doctors' Support Program 1300 687 327 (Australia) or 0800 666 367 (New Zealand). www.anzca.edu.au/about-us/doctors-health-and-wellbeing/doctors-support-program

Beyond City Limits



Destination Southland

Anaesthetists at Southland Hospital in Invercargill in New Zealand's South Island are surrounded by stunning landscapes and can hit the ski slopes in Queenstown and the iconic Milford Track in just over two hours.

"YOU HAVE TO treat whatever comes through the door," is a commonly used statement by doctors at Southland Hospital. In Invercargill that could mean absolutely anything. When you sit at the bottom of the South Island as one of the world's most southern and possibly most welcoming regional hospitals, you are prepared for them all.

Southland Hospital is a 157-plus bed level two hospital which has a catchment up to Queenstown and covers stunning Fiordland and down to Bluff and Stewart Island on the heaving ocean to Antarctica. That means it sits on the edge of some of the most stunning and edgy landscapes in New Zealand. As the anaesthesia department's clinical director (CD), Dr Helen Weir aptly states, Southland is an enormous playground.

The anaesthesia department comprises 14 senior consultants and six registrars. "I love it," says Dr Weir. "We are diverse. We all have one another's backs and there's good collegial support. When you look at the evolution of the department over the past 20 years to where we are at now – I'm really proud of it."

There are four theatres (they need more) and an endoscopy suite in the unit which is used for dental lists. They see about 5550 cases in the unit each year. "We have a significant paediatric caseload – lots of dentals, simple ear, nose and throat but we also have a congenital hip service and a paediatric surgical service (with a visiting surgeon). In general surgery we do (along with some bariatric work), orthopaedic (which includes pelvic fractures), obstetrics and gynaecology, eyes, maxillofacial (also with a visiting surgeon), and urology," says Dr Weir. "We see a large volume of orthopaedic trauma. We have a single intensivist, and this service is currently being reviewed to determine what it needs to look like in the future."

Dr Weir is the head of a very busy team, but she says Southland offers a really "great work/life balance". Nearly every FANZCA the *Bulletin* meets in Southland agrees. They marvel at the five- to 10-minute commute to work, how they can attend children's events at the drop of a hat, and how they are able to hit the ski slopes in Queenstown and the iconic Milford Track in just over two hours.

Dr Richard More, Dr Katherine Shute and Dr Jackie Blay.

Dr Richard More and family at Key Summit off the Routeburn Track.

"We all have one another's backs and there's good collegial support."

Invercargill is easy. The streets are unnaturally wide (harking back to the days when they thought trams should be a thing), and the traffic is almost non-existent from a big city point of view. It is friendly to the point of feeling like you are heading back a few decades, but don't confuse that with old-fashioned. There's a lot going on.

The city has attracted and retained FANZCAs such as Dr Richard More who moved here from Wellington seven years ago. Dr More and his GP wife Dayna, three boys aged between six and 11 years, and three pet sheep live on a two-hectare block less than 10 minutes from the inner city.

"The boys are having a great time here. The schools are really good and there are a lot of opportunities for outdoor activities," says Dr More. He mentions the ease of reaching Fiordland for tramping and central Otago for skiing. "But also, Stewart Island is only an hour by boat or a 20-minute flight and that's just a gorgeous place where you can spend time and slow down a wee bit."

Dr More was asked whether he would join the rowing team or the cycling team when he was interviewed for the position. He decided to go for the velodrome cycling corporate pursuit team made up of members of the department, and some spouses. This explains the numbers of photos of lycra-clad doctors spotted around the department. The infamous coast-to-coast endurance race is next on the cards for Dr More who will be teaming up with department colleague Dr Andy Whelan.

The collegiality of regional hospitals not only attracted Dr More but his colleague Dr Katherine Shute. The former Londoner was snaffled up by Dr Weir from Perth. Dr Shute and her GP husband and two boys made the move south four years ago. The easy commute makes life super enjoyable for this former city slicker. "It's nine minutes and if it's an emergency and on-call I can get in there [the hospital] in seven or eight minutes which is really nice. It makes being on-call a lot more enjoyable and less stressful."

Invercargill has an ageing population and Dr Shute says this means they deal with a lot of complex health problems. "Even if they are having what you might think of as minor operations, it's the comorbidities that can make things more complicated. But working in a regional centre you have to deal with whatever comes into the hospital. While some of the neuro or vascular patients will get transferred out, you obviously have to deal with them when they come in and stabilise them."

Dr Shute and Dr More talk about the range of the work. "I also enjoy looking after all different ages from children up to elderly adults. I enjoy doing obstetrics one day, to acutes the next,

"Happy doctors are doctors who do good work."

orthopaedics, general – I enjoy the variety," says Dr Shute. Dr More says the workload has increased over the past few years with the hospital groaning from the load. With the borders opening again they are expecting an increase in ski injuries and all that goes with adventure tourism in the region.

Sport has always been an integral part of Dr Jackie Blay's life so the move on to the velodrome team was a natural progression when she landed in Invercargill. She and her family were survivors of the Christchurch earthquakes and looking for a steady and not multi-storey existence in a less shaky part of the country. Invercargill offered that but so much more with the access to the outdoors, mountain biking, tramping, and skiing. "Our department head makes sure we can get the leave, so I've gone on to do some running races and orienteering, and the kids (13 and 16 years) make full use of our environment."

Dr Weir seems to be the magic that holds this very balanced department together. "Happy doctors are doctors who do good work," she says.

Invercargill seems to be the environment where that is made possible.

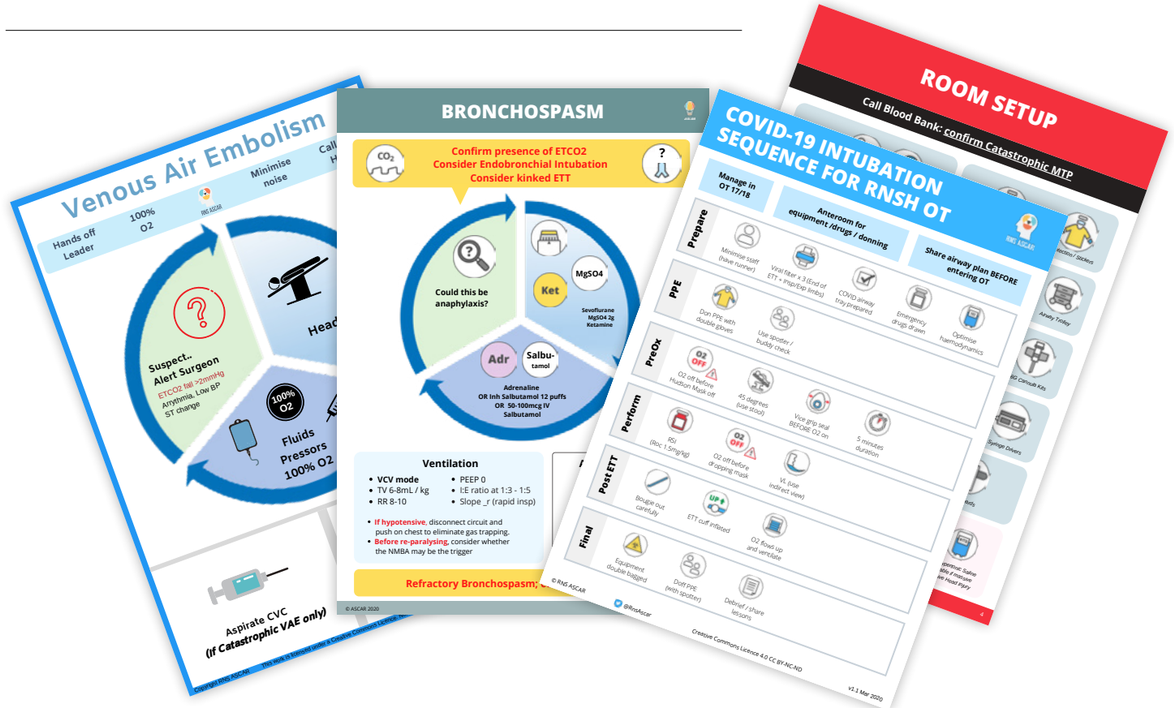
Adele Broadbent
ANZCA Communications Manager, NZ

Dr Katherine Shute and family on Coronet Peak ski field.

Lake Hauroko, Southland

Frontline crisis tool worth a thousand words

A passion project for four anaesthesia trainees from Sydney's Royal North Shore Hospital developed into a set of cognitive aids and crisis management tools that have helped play a key role in the hospital's COVID-19 response.



***"WE WERE WATCHING** the intracranial pressure (ICP) increase by 5, every five minutes. Once it hit 60, the tension in the room was palpable....."*

It was almost midnight, and the overnight call team was desperately trying to care for a patient with a catastrophic closed head injury. Time was critical, and given the severity of the situation, it was essential that no treatment options were missed.

Coincidentally, the anaesthesia registrar involved had just downloaded a cognitive aid app, something recently developed by a few of her colleagues for scenarios just like this.

"We went through the list of therapies and kept verbally reading them off, confirming we'd done each one.... Yes. Yes. Yes. Yes. . .

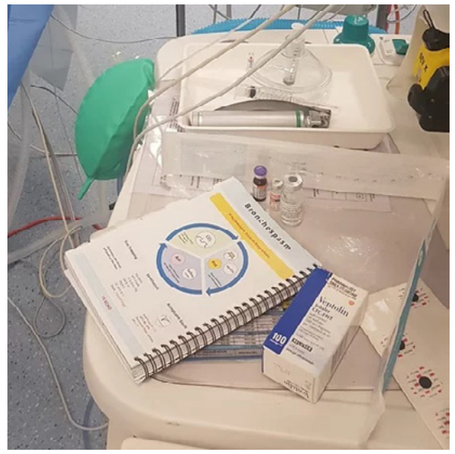
The ICP still kept climbing so we contacted the intensivist on-call for advice on anything else that could be done. They confirmed everything had been covered."

The story of how that app came into the registrar's hands is an inspirational one.

In 2019 Dr Dan Zeloof was an advanced trainee (AT-1), working through a cerebral aneurysm operation alongside a consultant with decades of experience in the field. In between tasks, he was seeking advice on responses to neuroanaesthetic crises. After searching for more related resources he discovered what he felt was a gap between the interventions and the thinking behind these compared to the cognitive aids he was encountering in the literature.

The aids he found were mostly checklists, in formats he felt were less visually functional for guiding thinking and processing information in critical situations.

Reflecting on previous experiences in critical events, Dan believed some of those situations may have benefited from resources that better addressed cognitive bias. This prompted him to use the wealth of clinical expertise available around him and develop something that filled that gap. The final goal was to produce an aid which was clinically valuable, visually accessible, and most importantly, functional in a crisis setting.



ASCAR resources (above), including the manual and cards are used in theatre by anaesthetists.

Remarkably, while working on the initial iterations of what would become a neuroanaesthesia crisis cognitive aid, another registrar in the anaesthesia department – Dr Jessie Maulder – was simultaneously working on a similar project. A collaboration ensued, bringing together like-minded clinicians with a mutual interest, and ability, to reach a common goal.

When a final product started to emerge (a hard copy manual), requests for similar aids in other areas began appearing.

Soon after, partially in response to the increasing appeals for other resources, two additional anaesthesia registrars from the department joined the team.

Dr Daniel Moi has had a serpentine career path. Stepping away from medicine for a few years, he focused on a combination of graphic and software design skills in a variety of industries. When Daniel returned to Royal North Shore Hospital to complete his anaesthesia training, his creative skills brought an invaluable addition to the group.

This is reflected in the hundreds of bespoke icons and graphics that are now synonymous with AnaeSthesia Cognitive Aids and Resources (ASCAR).

Dr Dushyant Iyer entered the picture with a well-established background in multimedia and educational podcast production. He co-founded the Junior Docs Podcast, a globally viewed resource aimed at helping medical students transition into becoming junior doctors. His vision and skillset provided an ability for the burgeoning group to now integrate audio and video mediums into their designs. Transitioning the group's work into digital iterations made accessing the content more practical and accelerated its integration for clinical use.

Collectively, these four trainees established a shared vision to create, refine, and produce high-quality cognitive aids and crisis management tools. Their passion project rapidly developed into what became the ASCAR group. Soon after, this played an essential role in Royal North Shore's Covid 19 response systems.

As the healthcare system reacted to the emerging information surrounding SARS-CoV-2's characteristics, changes in workflow and modifications to protocols seemed to occur almost weekly.

> "The material they've produced is at the standard one would expect from a large university consortium, yet it comes from an energetic and dedicated tiny band of champions."

A need for staff to rapidly adapt to the constantly evolving practice guidelines found an invaluable ally in ASCAR. They worked tirelessly to quickly develop, test, and integrate new cognitive aids to keep pace with the variety of new protocols and standards that were implemented.

Having this information available in a functional format lent a valuable degree of reassurance for our frontline staff during the emerging pandemic response. ASCAR's utility subsequently led to a collaboration with the Safe Airway Society to rapidly develop and distribute a COVID-19 airway management guide.

According to Dr Adam Rehak, executive member of both the Safe Airway Society and the Airway Management Special Interest Group:

"These guys are good. [They] have been producing cognitive aids and infographics for Royal North Shore Hospital for a while, but when we asked them to produce cognitive tools for the COVID-19 guideline with a rapid turnover of within 48 hours (over the weekend) . . . they delivered in spades."

Generating resources like these requires a trifecta of skills: An expertise in the relevant content, a high degree of technical ability in designing the final product, and an adeptness at scaling and distributing the material to ensure it is used.

A sample of ASCAR resources ready for use.

Clockwise from top left: Dr Dushyant Iyer; Dr Dan Zeloof; Dr Jessie Maulder; Dr Dan Moi

To corroborate that the resources produced were well vetted and of a high quality, Dan and Jessie initially sought advice from several international groups with a well-established track record of generating similar resources (like the World Health Organization's Surgical Safety Checklist and the Stanford Emergency Manual for Perioperative Critical Events). This led to ongoing conversations and mentoring that ingrained a high degree of professionalism and quality assurance measures in the group's workflow.

Dr Alex Hannenberg is a founding board member of Lifebox, a senior research scientist, and faculty member in the Safe Surgery Program at Harvard's Ariadne Labs (one of the leading institutions worldwide for health systems innovation). Early on, ASCAR reached out to him for mentoring to ensure there was adequate rigor in the processes being used to develop the material. We contacted Dr Hannenberg, as an experienced professional in this area, for his opinion. He noted that:

"The material they've produced is at the standard one would expect from a large university consortium, yet it comes from an energetic and dedicated tiny band of champions. They have rapidly become notable contributors to the movement that embraces cognitive aids in healthcare to improve reliability of management in critical events."

ASCAR now boasts a myriad of experts in numerous clinical specialties, human factors management, graphical and digital design. Their overarching goal is to enable optimal performance during crises by designing clinical management tools that are refined for high-stakes environments.

Following the initial neuroanaesthesia crisis manual, the group continued to produce resources across a range of sub-specialty areas, from airway management techniques to obstetric emergencies, and even a structure for team huddles prior to entering COVID isolation areas. Their compendium includes tools for neuroanaesthesia, trauma, obstetrics, general anaesthesia, neonatal resuscitation, airway management, paediatrics, and more, all focused around attempting to succinctly represent current best practice.

Speaking with them now, as two of the members have moved on to consultancy, and others continue to join the fray, we asked what their vision and hopes are for the group's future. They spoke optimistically about a desire to see ASCAR continue to grow and collaborate, both locally and internationally. With continued efforts to improve and advance its content, their work emphasises the importance of having locally relevant resources to aid our responses to critical events.

There is a hope that the group will develop the critical mass of infrastructure and resilience to become an enduring resource to the medical community.

The ASCAR group's resources have now been woven into a website and an iOS-based app, available for anyone to use, and can be found at www.ASCARgroup.com.

Dr Matthew Doane, FANZCA
Dr Geraldine Khong, FANZCA
Royal North Shore Hospital, Sydney

Dr Matthew Doane

Dr Geraldine Khong

Self matters

The challenge of change

When considering wellbeing in our workplaces, we often see many things we would like changed. It may feel hard to know where to begin. Dr Jess Lim and Dr Bec McNamara, NSW wellbeing advocates, describe their practical approach to this challenge – their simple and powerful message is "just start". The small pieces can add up to a powerful whole. And support is readily available – see the breakout boxes for their tips.

My thanks to Dr Tanya Selak for putting me in touch with these fellows and their work, and to Dr Jo Sinclair for editorial advice. As always, I welcome ideas for future columns and writers to lroberts@anzca.edu.au.

Dr Lindy Roberts AM
ANZCA Director of Professional Affairs, Education

A practical guide to wellbeing by a couple of non-experts

ENSURING THE WELFARE of our trainees and colleagues has become front of mind in recent years. Despite our improving familiarity with the challenges and stressors of practising in COVID times, the greatest challenge remains – prioritising our own health and safety.

We are not experts, just a couple of friends who share our experiences promoting wellbeing in our home hospitals over the past five years. While wellbeing can often seem intangible and difficult to attain, we have found that many small things come together to make a big difference.

We've been lucky to work in wider wellbeing teams, with the support of the Sydney Local Health District wellbeing body, Medical Doctors OK (MDOK). The initiatives we describe are due to a wonderful team effort – a special shout out to Shanel Cameron, Katherine Gough, Amy Lawrence, Kar-Soon Lim, Rod Martin, Veronica Payne, Anand Rajan, John Stellios and Amanda Smith.

EARLY STAGES

Sow the small seeds

It was really daunting to know where to begin... so we started small. Reviving the annual departmental picnic provided a chance for everyone to relax and catch up outside of work. Other early initiatives included theatre-wide bake-offs, a city2surf team, and regular Friday after-work catch-ups. Even though it didn't feel like it at the time, all these seemingly trivial initiatives helped plant the seeds of wellbeing in our department: interconnectivity, support, community.

Get the lay of the land

Touching base and listening to department members has been invaluable. Engaging face to face with trainees on what concerns them, as often as possible, has been important. We've also found anonymous surveys that gather opinions are useful for understanding what the big issues are and how best to address them.

Get the band together

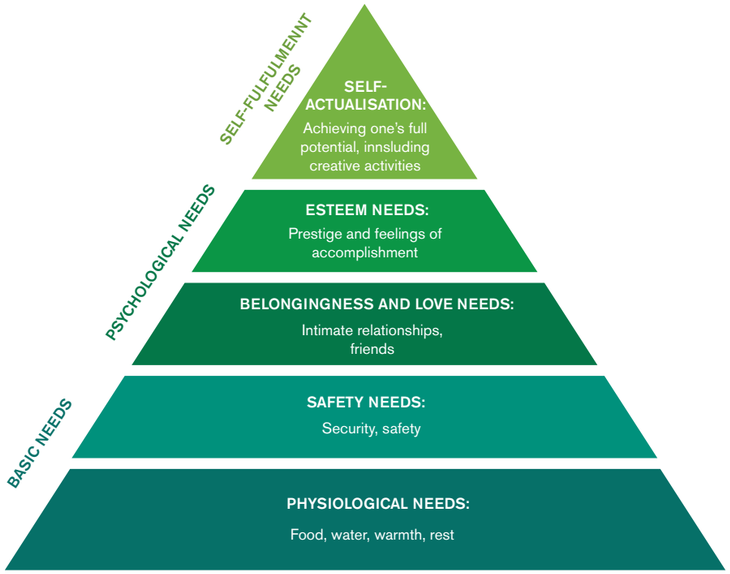
The most rewarding part of our mission has been the people with whom we've worked. At the start of the pandemic, we combined existing mentor and wellbeing interest groups into a "wellbeing team". This team was a source of inspiration, a great forum for brainstorming ideas, and a much-needed sense of human connection in what was a very isolating time. Regular NSW wellbeing advocate meetings connected us on a wider scale. Participating in the Wellbeing Special Interest Group (SIG) provided another layer of encouragement.

GETTING IT DONE

Maslow's hierarchy, a five-tier model (see page 36) of needs that must be satisfied for wellbeing, serves as a good basis for thinking about initiatives. Each level must be satisfied before the next can be successfully addressed.

Basic needs

Satisfying our basic physiological needs is an easy and essential starting point. We introduced a department snack corner with tea bags and coffee pods for a donated coffee machine. Our wellbeing team worked with MDOK to introduce "theatre toasties" and healthy vending machines to provide food for after-hours staff. This involved a trial, followed by a business proposal to the hospital executive including a survey demonstrating its widespread benefits. These early gains generated buy-in and traction to tackle the more challenging higher-tier needs.



Physical wellbeing

We have introduced various physical wellbeing initiatives to the department – a great way for people to connect outside of work and build physical wellbeing. These include morning outdoor yoga sessions before work and an inter-hospital run club.

Psychological wellbeing

Our psychological wellbeing initiatives included Zoom social events during lockdown, Christmas dinner vouchers for the trainees in lieu of the cancelled Christmas party and COVID-safe social gatherings. Pandemic-specific initiatives included isolation packs to support colleagues in isolation, picnic packs to encourage human interaction in small COVID-safe groups at work, and an intensive care unit debrief session. Although minor individually, together these initiatives have boosted morale and instilled a sense of belonging and community.

KEEPING THE MOMENTUM

Connection and communication

These have been key to all of our wellbeing initiatives. Early in the pandemic, we started a wellbeing newsletter, a forum to share departmental "good news stories" and non-COVID news. We developed a wellbeing website to centralise resources, with information on where and how to access help. We have supported existing systems, such as our mentor program, to ensure individual support. Connection was also promoted by our regular Zoom department meetings and teaching sessions.

Empower yourself and your team!

So many of us find ourselves in medicine and in mentoring or supervisory positions because we want to help people, but most of us have never had any formal training. To empower and upskill our team we undertook team training in mental health first aid. We organised departmental education sessions with the psychologist from our local Employee Assistance Program (EAP). These then progressed to regular wellbeing sessions within our departmental continuing medical education (CME) meetings. We also organised a six-week mindfulness program run by one of our fellow wellbeing team members who also happens to be a mindfulness guru!

THE FUTURE IS BRIGHT

Fly your wellbeing flag!

Raising the profile of wellbeing in your department, hospital or practice is the ultimate challenge. Cultural change takes time, it takes patience, it takes people. It encompasses all the seemingly "trivial" initiatives as much as the top-down system-based policies and protocols. Our wellbeing journey is still relatively young, but we have hopefully seen the first signs of our wellbeing seed growing – senior consultant contributions to wellbeing initiatives such as the newsletter, yoga and mindfulness, support by the head of department for wellbeing presentations at department meetings, regular wellbeing updates at department and executive committee meetings – all contributing to wellbeing being seen as a key priority.

So to anyone out there organising picnics, debriefs and mindfulness training – don't undersell yourself and don't underestimate all the seemingly "trivial" things you have done! Over time, they can add up to something immense. You don't need to be an expert to start the change, you just need to start.

Dr Jess Lim, FANZCA
Concord Repatriation General Hospital and Royal Prince Alfred Hospital, Sydney

Dr Bec McNamara, FANZCA
Royal Prince Alfred Hospital, Sydney

Dr Jess Lim and Dr Bec McNamara

PRACTICAL POINTERS:

Just getting started? Here's four things you can organise for your department now!

1. Join the Wellbeing special interest group (SIG) and sign up for their 2022 combined SIG meeting.
2. Create a departmental Wellbeing interest group and appoint a Wellbeing Advocate to represent your department at the regular Wellbeing Advocates network meetings in your region/country. (More information on the network and how to join can be found at www.anzca.edu.au/about-us/doctors-health-and-wellbeing).
3. Organise a department wellbeing CME session.
4. Formalise your department's existing mentoring or peer support arrangements (for example, schedule social and training events for mentors and mentees to facilitate interaction and skills acquisition).

ONE-STOP SHOP RESOURCES:

Here are our top tips for practical wellbeing guides:

- Wellbeing SIG Library guide (https://libguides.anzca.edu.au/wellbeing).
- Long Lives, Healthy Workplaces: Our hot tip is the four and nine page summaries at https://www.anzca.edu.au/about-us/doctors-health-and-wellbeing/long-lives,-healthy-workplaces.

LOOK AFTER YOURSELF FIRST!

Fill your own cup before you can fill others:

- Take a moment (or even a day) to prioritise your own self-care. Looking after yourself and scheduling time for personal development, relaxation and fulfillment is an important step towards changing our culture.
- Get a GP – you don't want the first time you talk to them to be as a stranger when you're going through a crisis.
- Download the EAP Connect app https://appadvice.com/app/eap-connect/1118947629 – so it's easily available when you or your colleagues need it. Reduce possible barriers to accessing or offering help. The service is free and anonymous and the team at Converge are specially trained to understand the unique needs and challenges faced by anaesthetists.

Free ANZCA Doctors' Support Program

How to make an appointment:

To speak with a counsellor over the phone or make an appointment to see a consultant for a face-to-face session:

- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand.
- Email eap@convergeintl.com.au.
- Identify yourself as an ANZCA/FPM fellow, trainee or SIMG (or a family member).
- Appointments are available from 8am to 6pm Monday-Friday (excluding public holidays).
- 24/7 emergency telephone counselling is available.

Converge international

HELP IS ALSO AVAILABLE VIA THE

Doctors' Health Advisory Services:

NSW and ACT	02 9437 6552
NT and SA	08 8366 0250
Queensland	07 3833 4352
Tasmania and Victoria	03 9280 8712
WA	08 9321 3098
New Zealand	0800 471 2654
Lifeline	13 11 14
beyondblue	1300 224 636

Keeping calm and batting on is the name of the game

Wollongong anaesthetist Dr Shiva Hampasagar helped found a local cricket club that now has five teams and male and female players from multicultural backgrounds.

AS A LIFELONG cricket tragic and all-rounder, ANZCA fellow Dr Shiva Hampasagar didn't waste any time in deciding on the name of the local cricket club he helped to set up in his home town of Wollongong.

That club, the Illawarra Passionate Cricketers' Club (IPCC), was formed in 2017 and became affiliated with Cricket Illawarra (the Illawarra Cricket Association) in 2020. The IPCC now has five teams including an under-13 mixed team and a women's cricket team.

Born and educated in India where he completed his medical degree at the University of Mysore and had trained as a cardiac anaesthetist, Dr Hampasagar migrated to Australia in 2006 from Singapore with his wife Prashanthi who is now training to be a dentist.

As a specialist international medical graduate he first settled in Tasmania, working in Burnie in the northwest of the state and then achieving ANZCA fellowship in 2007. The couple then moved to Wollongong in 2010 where their son, Ishaan, now nine, was born.

A visiting medical officer at Wollongong Hospital Dr Hampasagar also works in private practice where he focuses on neuro-anaesthesia. He was instrumental in creating a unique community cricket association for the region. He has brought together a diverse group of Wollongong locals, including players with Sri Lankan, Bangladeshi, Pakistani and Indian backgrounds, together for seasonal cricket games. Several local anaesthetists and other medical specialists are also members of the club.

As club president Dr Hampasagar is proud of what the players have achieved in the last five years.

Until the onset of COVID-19 the non-profit organisation organised a Spring IPCC cricket tournament each year. The club is hoping to be able to resume that flagship event later this year with a 2022 spring tournament with teams from the Illawarra region, Sydney and Penrith.

"This just gives me so much pleasure," he told the *ANZCA Bulletin* as he prepared for the club's annual presentation night. "We started the women's cricket team last year and we successfully ran the whole season, mostly with players from an Indian background but also with some locals too."

"I'm so thankful to the locals who have embraced the club. They helped us so much and have contributed so much. I was really just chasing a passion but it's great to see so many others now involved.

"When I arrived here I met a few like-minded people who wanted to play cricket. We started a team just so we could have some fun but after six months we realised that perhaps we could do a bit more."

Dr Hampasagar's dream was to showcase multi-cultural cricket in Wollongong and promote it as a family friendly event.

"Our games soon became very popular and each year everyone started looking forward to it. I thought it was important to encourage the players' families to show their support for the club by attending matches and celebrating the success of their family members who played.

"It's important that we promote all the nationalities who play for the club so we can understand each other's culture. It's also important to be able to encourage the players and their families to be part of the club and to promote family sports in the local community with social cricket events and local grade competition cricket."

Dr Hampasagar's goal is to encourage and guide the club's younger players with the aim of having at least one or two of the club's players playing at national level.

"My aim is to bring at least one player to a national team in five years' time and contribute to Australian cricket. That would be a great achievement for the club," he says.

Carolyn Jones
Media Manager, ANZCA

From top: Dr Hampasagar (left) with the IPCC juniors team; Dr Hampasagar (left) relaxing after a game with Club captain Itwik Joshi and (right) club player Dr Matthew Threadgate, a Wollongong urologist; An IPCC team before a game.

Photos: supplied

Safety and quality

ANZCA and the coroner

Cardiorespiratory arrest following propofol administration in a dental practice

WE WERE GRATEFUL to hear from the Victorian Coroner in October 2021 about a recent finding with inquest on the death of a 36-year-old man, Mr A, with borderline cardiomegaly in April 2017, from cardiorespiratory arrest complicating propofol administration for an endodontic root canal procedure.

HISTORY

Mr A's only known relevant medical history was that he could be classified into World Health Organization (WHO) Obesity Class II, with a Body Mass Index (BMI) of 38.5 kg/m², and reported anxiety about dental procedures. This anxiety, combined with a previous unsuccessful attempt at completing the procedure with local anaesthetic alone, was the reason he was offered what was described as "conscious sedation" via propofol for this second attempt at the procedure.

EVENTS SURROUNDING MR A'S DEATH

The procedure took place in a private dental surgery. Propofol was administered by an anaesthetist, who monitored Mr A's condition while the endodontic surgeon carried out the procedure. About 10 minutes into the procedure, Mr A's oxygen saturation levels began fluctuating, followed by episodes of bradycardia. The procedure was promptly suspended and jaw thrust was administered, followed by insertion of an oropharyngeal airway and commencement of bag and mask ventilation. Despite this, Mr A's pulse became undetectable and cardiopulmonary resuscitation was commenced. Emergency services were called, and automated external defibrillation (AED) and adrenalin were administered.

Emergency services were faced with having to travel through a crowded commercial office building, then carry out resuscitation tasks and transfer the patient by stretcher from the confined floor space of the dental surgery. Nonetheless, both the Metropolitan Fire Brigade (MFB) and the Mobile Intensive Care Ambulance (MICA) paramedics were satisfied with the resuscitation procedures in use at the time of their arrival.

Automated chest compressions continued while Mr A was transported to hospital. However, on cardiac ultrasound in the emergency department, there was no cardiac movement or output detected, and Mr A's pupils were fixed and dilated. Shortly afterwards he was declared deceased.

FINDINGS OF THE INQUEST

The inquest heard from several expert witnesses and concluded that referring a patient for a procedure involving propofol in a private office setting was reasonable and usual given Mr A's relatively young age and good health, and despite his obesity.

The access difficulties to the dental surgery were noted, but were concluded not to have prevented appropriate resuscitation.

Regarding the finding of borderline cardiomegaly due to left ventricular hypertrophy that was returned at autopsy, the experts advised that even if this finding had been known prior to the procedure, it would not have been sufficient to contraindicate propofol administration.

Ultimately, the coroner made no adverse comment against any individual, and was not able to conclude that Mr A's death was preventable.

The coroner made recommendations that ANZCA:

- Develop guidelines around the use of conscious sedation/anaesthesia, including but not necessarily limited to propofol, in the dental practice setting on patients within WHO Class II and Class III obesity.
- Use the circumstances surrounding the death of Mr A as an educational tool for emphasising the importance of documenting vital signs following the administration of anaesthetic.

ANZCA'S RESPONSE

In response, we were able to advise the coroner of the collaborative review currently in progress of our *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*, which involves 26 other stakeholder groups involved in the sedation of patients, including the Royal Australian College of Dentists, Australian Dental Association, and the Australian Society of Dental Anaesthetists. This case will be referred to all stakeholders for discussion.

Additionally we advised that reference to documenting vital signs following the administration of anaesthetic appears in our professional documents *PG06(A) Guideline on the anaesthesia record*, *PG18(A) Guideline on monitoring during anaesthesia* and its associated background paper PG18(A)BP. These documents are available on the ANZCA website.

AFTERWORD

We thank the Coroners Court of Victoria for the opportunity to review and reflect on this case, and offer our sincere condolences to the family of Mr A for their loss.

The inquest finding and ANZCA's response are available on the Coroners Court of Victoria website.

ANZCA typically receives several Coroners' findings per year from the range of Australian and New Zealand jurisdictions that the college represents. Responses are considered in the first instance by the Chair of our Safety and Quality Committee, and our Director, Professional Affairs – Professional Documents, with referral for further advice to the Safety and Quality Committee or other fellows with special expertise where needed. We thank all contributing fellows for their time and expertise.

A call-out to stand up for standards

SINCE 2005 ANZCA fellow Dr Phoebe Mainland has been a respected voice for anaesthesia and respiratory medicine as a member of an international committee that develops global standards for equipment, supplies and related devices for the specialty.

A visiting medical officer (VMO) at Alfred Health in Melbourne, she relishes the voluntary role. While she plans to continue for some time yet she hopes a new generation of like-minded and interested fellows can be encouraged to contribute and participate in this important work.

Dr Mainland has spent several years in her role as a Standards Australia-appointed member of the International Organization for Standardization (ISO) developing the international standard *ISO 80369-6:2016 Small bore connectors for liquids and gases in healthcare applications Part 6: Connectors for neuraxial applications*. Her expertise was recognised with a Churchill Fellowship in 2015/16 to enhance the safety of Australian patients by reducing misconnections between medical devices in the UK and the US.

"Australia's involvement in the ISO committee is well respected and the clinician involvement appreciated," she says.

"You don't have to be an expert in equipment – I'm not – but it's more that the clinical perspective is so invaluable. It's an amazing opportunity and learning experience as you work with other industries, manufacturers, engineers, consultants and regulatory agencies. By working on international committees with anaesthetists and anaesthesiologists from other jurisdictions you also learn more about the different ways people work."

Up to six positions to Standards Australia (SA) committees can be nominated by ANZCA and the Australian Society of Anaesthetists (ASA) (three for each) as member bodies but fellows can also apply for additional positions that do not require college or society nomination. Dr Mainland encourages any fellows to consider nomination, as a position on an SA committee can then lead to representation on the Geneva-based ISO.

Dr Mainland is joined on the Standards Australia (SA) committee for *Medical Gas Systems* (HE-017), and the ISO/TC (Technical Committee) 121 *Anaesthetic and respiratory equipment* by Australian fellows Dr Ted Murphy and Dr Ben Waldron but as yet, there are no New Zealand fellows on the ISO committees. The SA HE-017 is the mirror committee for ISO/TC 121. ISO/TC 121 consists of several sub-committees and two working groups (see breakout box below) including ongoing assessment of airways devices and anaesthetic machines.

"Because we're the end users of the devices it's important that we contribute to the development of the device standards. We really do have insights that others don't," she explains.

"Other members of the committees are often manufacturers, engineers, suppliers, contractors, and regulatory agency people such as the Therapeutic Goods Administration. It's all great to have that input and expertise but our clinical perspective is highly regarded. Internationally, Australia has traditionally had a strong clinician representation on the ISO/TC 121 committee for example.

> "If you're not happy with something, if you think this could be done better, it's an opportunity to speak up about it and provide feedback."

"It's important that the college and the ASA continue to support this representation as other countries often don't provide the same support to their clinicians for involvement as members of international standards committees.

Dr Mainland chairs the ISO/TC 121/SC 8, the sub-committee for suction devices and the ISO/WG 1, working group for connectors for respiratory therapy devices and accessories. Her standards work also includes a role as liaison for the World Federation of Societies of Anaesthesiologists (WFSA) with ISO/TC 121 and with ISO/TC 210 *(Quality management and corresponding general aspects for medical devices.)*

Dr Mainland is keen to increase the specialty's representation on HE-017 and via Standards Australia on ISO/TC 121. She hopes that as more fellows join standards committees a group of "standards fellows" could then form an ANZCA/ASA standards group for ongoing discussion and support. Her ongoing work with the ISO committees focuses on airway devices, anaesthesia machines and connectors.

"This work really does contribute to the safety of patients and it's important that the equipment is manufactured to reflect clinical considerations. If you're not happy with something, if you think this could be done better, it's an opportunity to speak up about it and provide feedback."

Over the years Dr Mainland joined ANZCA fellows Professor John Russell, Dr Chris Joseph, Dr Mark Fajgman and later Dr James Derrick as members of committees for equipment standards.

Carolyn Jones
Media Manager, ANZCA

Fellows who are interested in pursuing a Standards Australia committee role can contact sq@anzca.edu.au. New Zealand fellows can find out more information at Standards New Zealand.

More information about Standards Australia's ambition to foster the next generation of standards developers can be found through its NEXTgen program.

ISO SUB-COMMITTEES AND WORKING GROUPS

SC 1 Breathing attachments and anaesthetic machines Structure: https://www.iso.org/committee/51986.html Standards: https://www.iso.org/committee/51986/x/catalogue/p/1/u/1/w/0/d/0	**SC 6 Medical gas supply systems** Structure: https://www.iso.org/committee/52026.html Standards: https://www.iso.org/committee/52026/x/catalogue/p/1/u/1/w/0/d/0
SC 2 Airways and related equipment Structure: https://www.iso.org/committee/52006.html Standards: https://www.iso.org/committee/52006/x/catalogue/p/1/u/1/w/0/d/0	**SC 8 Suction devices** Standards: https://www.iso.org/committee/52038/x/catalogue/p/1/u/1/w/0/d/0
SC 3 Respiratory devices and related equipment used for patient care Structure: https://www.iso.org/committee/52012.html Standards: https://www.iso.org/committee/52012/x/catalogue/p/1/u/0/w/0/d/0	**WG 1** Connectors for respiratory therapy devices and accessories
SC 4 Vocabulary and semantics Structure: https://www.iso.org/committee/52024.html Standards: https://www.iso.org/committee/52024/x/catalogue/p/1/u/0/w/0/d/0	**WG 3** Cybersecurity for anaesthetic and respiratory equipment recruit.

Safety alerts

Safety alerts appear in the "Safety and quality news" section of the *ANZCA E-newsletter* each month. A full list is available on the ANZCA website: www.anzca.edu.au/safety-advocacy/safety-alerts.

Recent alerts:

- Misaligned volume markings on BD 5mL syringe
- Two product defect corrections: Medtronic NIM EMG Endotracheal Tubes
- Product defect correction: Getinge Sevoflurane Quik-Fil Vaporizer, yellow substance in vaporizer
- CO_2 insufflation in endoscopy reduces risk of gas embolism
- Product defect correction: Carestation 750/750c Anesthesia Delivery Systems – O_2 mixer failure conditions
- Product defect correction: damaged barrels on BD Plastipak 50mL Syringe with Luer-Lok Tip
- Management of potential supply disruption to epidural kits
- Product defect correction: Medfusion syringe pumps models 3000 and 4000, eight issues

OSA – the unknown unknown

Christchurch anaesthetists Dr Pippa Jerram and Dr Leesa Morton have developed guidelines to manage patients at risk of perioperative complications of obstructive sleep apnoea (OSA). The guidelines are proving a hit with clinicians.

"Reports that say that something hasn't happened are always interesting to me, because, as we know, there are known knowns; there are things we know that we know. There are known unknowns. ... But there are also unknown unknowns. There are things we do not know we don't know."

– Donald Rumsfeld US secretary of defence 2001-2006

KELLY (AGE 51) WAS not sure if she had OSA or not. She scored 5/8 on her STOP-BANG screen and was awaiting diagnostic sleep studies when she presented for an elective L4/5 TLIF. Her anaesthetist identified her as being at high risk of perioperative complications of OSA and gave her a careful anaesthetic avoiding long acting sedatives and using multimodal analgesic agents. Kelly had an increased level of postoperative care after her elective operation, with continuous pulse oximetry and high flow nasal oxygen.

Unfortunately, Kelly developed a wound infection and went on to have several more general anaesthetics as an inpatient. Despite the care taken with her initial anaesthetic, her subsequent ones reflected a more standard level of care for a surgical patient, with low flow oxygen, opioid based analgesia and standard post operative ward care. She went on to develop respiratory failure and spent several nights in the ICU before eventually being discharged from hospital seven weeks later.

It is impossible to attribute her unfortunate trajectory to any one factor. However, the lack of a standardised approach to patients at risk of the perioperative consequences of OSA was evident throughout this case.

The role of the anaesthetist involves assessing patients thoroughly, and applying knowledge and skills to achieve the best perioperative outcome for the patient. This care does not stop when the patient is transferred from the operating theatre. Physiological disturbances identified in the pre-anaesthetic assessment, or in the course of an anaesthetic, are incorporated into decision making to inform appropriate postoperative deposition and care.

But what happens when the pathology is not apparent to the anaesthetist? Such is the case with sleep-disordered breathing (SDB).

Obstructive sleep apnoea (OSA) is the most common type of SDB. OSA is a sleep disorder caused by recurrent partial or complete closure of the upper airway during sleep. Risk factors include being overweight, male gender, family history and upper airway abnormalities. The perioperative effects of OSA include consequences of the structural disease such as difficult airway management, hypoventilation and hypopnoea – but also consequences of the sustained effects of recurrent nocturnal hypoxaemia. Patients with OSA suffer metabolic and cardiovascular disease secondary to their OSA, and have an altered responses to opioids and other respiratory depressants[1].

OSA is associated with excess postoperative morbidity, and carries an increased risk of both medical and surgical complications[2].

Anaesthetists are often oblivious to the presence of OSA. The reasons for this are many. As is well established, the majority of patients with OSA are unaware they have it[3]. Because symptoms occur during sleep they are unable to let their clinician know when asked the question. The cardinal daytime symptom of fatigue is not elucidated in routine anaesthetic assessment unless the anaesthetist is particularly vigilant to the possibility of OSA. Sequelae of OSA such as diabetes, hypertension and atrial fibrillation are treated as diseases in themselves and seldom attributed to OSA by most anaesthetists, even though it is well established that OSA frequently drives these conditions[4].

Another important reason for the anaesthetist's nescience to OSA is about "skin in the game". Despite there being many perioperative implications of OSA there are relatively few that directly affect the anaesthetic. The most common is difficult airway management. This is core business for anaesthetists and while the presence of OSA should prospectively warn us of the likelihood of difficult airway management, we may be less likely to retrospectively attribute a difficult airway to undiagnosed OSA.

Even if the diagnosis is established (or suspected) there is a paucity of guidelines for perioperative care that are appropriate to the Australasian resource environment. Many established guidelines from overseas presume the ready availability of beds in high dependency (HDU)-type settings. These guidelines are rarely realistic in our resource-constrained hospitals. As such, when we are faced with the alternative of cancelling patients, surgery will commonly proceed without a monitored bed postoperatively.

The net effect is a tendency to both underdiagnose and undertreat patients with OSA, despite the known increase in perioperative risk.

Our aim was to develop a targeted guideline for the safe perioperative care of patients with or at risk of OSA in our hospital in Christchurch, New Zealand (see figure 1).

Prior to the development of these guidelines, we audited the perioperative management of OSA at our hospital, looking at identification of patients with or at risk of this disease, and their perioperative management. Our findings reflected the literature showing patients with or at risk of OSA were at increased risk of adverse postoperative outcomes including; surgical complications, extended hospital stay and increased need for critical care intervention. We also observed a lack of vigilance to the diagnosis.

Audit data enabled us to identify patients with a STOP-BANG of at least 2-4 on age, BMI, gender and medication alone. The majority of these patients were identified as being at "no risk" of OSA by their anaesthetist, without performing a STOP-BANG.

The guideline addresses the identification of these patients, and outlines a care pathway that integrates OSA severity, comorbidity, surgical extent and postoperative analgesia requirements. Key features of this care pathway include an ability to modify the risk score based on not just features of history and examination but also early post-operative events. An extended PACU stay maximises the observation window for this. We have also worked with ward staff to enable targeted monitoring of patients at elevated risk without requiring an HDU bed.

The objective of these guidelines is to maintain patient safety and improve post-operative outcomes while staying within the resource capability of our hospital.

Whether or not we achieve this objective remains, at this stage, another unknown We will address this unknown with further audit and if necessary, refinement of the guideline.

Dr Pippa Jerram FANZCA
Dr Leesa Morton FANZCA
Christchurch Hospital, New Zealand

FIGURE 1 – SCREENING FOR OSA RISK

If the patient meets **2 or more** of the following criteria, a STOP-BANG questionnaire should be done

- Snoring
- Witnessed apnoea
- Choking sensation which causes patient to wake from sleep
- Two or more anti-hypertensives
- BMI > 30

Or any patient in whom there is a suspicion of SDB based on clinical judgement.

***Further simple investigations include**
CBC
Renal function
HbA1c
Venous bicarbonate. ≥27 should prompt consideration of obesity hypoventilation syndrome (OHS)
ECG – looking for arrhythmias or right heart strain

S	When sleeping: do you **SNORE** loud enough to be heard through closed doors or does your partner elbow you for snoring
T	During the day: Do you often feel **TIRED**, sleepy, fatigued or fall asleep while driving or talking to someone
O	When you are asleep: Has anyone **OBSERVED** you stop breathing, choke or gasp
P	Do you have, or are you being treated for high BLOOD **PRESSURE**
B	Is your **BMI** greater than 35
A	Are you older than 50 years of **AGE**
N	Is your **NECK** measurement bigger than 40cm
G	**GENDER** – are you male

A STOP-BANG score of ≥5* indicates increased probability of moderate to severe OSA – **go to step B**

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3. Singh M, Liao P, Kobah S, Wijeysundera DN, Shapiro C, Chung F: Proportion of surgical patients with undiagnosed obstructive sleep apnoea. Br J Anaesth 2013; 110:629–36
4. Bradley T, Floras J. Obstructive sleep apnoea and its cardiovascular consequences. The Lancet 2009;373:82-93

Dr Leesa Morton

Dr Pippa Jerram

Updated guideline on surgical patient safety and COVID-19

ANZCA has released the second edition of the professional document PG68(A) *Guideline on surgical patient safety for SARS-CoV-2 infection and vaccination.*

THIS UPDATED "LIVING GUIDELINE" document provides current advice to fellows, trainees and specialist international medical graduates on navigating surgical patient safety concerns in the changing environment of the SARS-CoV-2 (COVID-19) pandemic.

This new edition has been produced via ongoing review of best available clinical evidence and relevant regulatory guidance. It takes account of helpful feedback from a number of our fellows, as well as other health sector colleagues.

A number of changes have been made for this edition, including a minor title change.

Updates relating to the safe timing of non-urgent elective surgery after SARS-CoV-2 infection

Our general recommended delay of non-urgent elective major surgery after confirmed infection has changed to seven weeks. This assumes the patient has returned to baseline function and is symptom free. Our previous recommendation of eight weeks was based on evidence published earlier in the pandemic. As more patient data has emerged, the conclusions of the international research literature have been refined, and opinion now largely coheres around seven weeks, when perioperative risk is shown to return to baseline.

Our previous recommendation to delay non-urgent elective minor surgery for four weeks, provided the patient has returned to baseline function and is symptom free, remains unchanged. To assist decision-making, we have sought to clarify what is considered major versus minor surgery, bearing in mind this is a grey area with no global consensus definition.

All patients should have an individualised risk assessment.

Time-sensitive surgery including cancer

Fellows have let us know that getting patients with cancer into urgent surgery without undue delay is an increasing source of concern.

Our advice continues to be that the general recommendation does not apply to time-sensitive surgery such as cancer. Unfortunately, there is ongoing uncertainty as to how long these surgeries should be delayed after a SARS-CoV-2 infection. Hence, the optimal timing must be determined via shared decision-making, informed by multidisciplinary individualised risk assessment, making note of the current evidence of perioperative outcomes for post-SARS-CoV-2 surgical patients.

The current evidence is that perioperative outcomes start to improve after two weeks post confirmation of infection, predominantly in the asymptomatic group of patients. However, perioperative risk only returns to baseline seven weeks after infection for both asymptomatic patients and symptomatic patients with resolved symptoms. Patients with persistent symptoms at seven weeks have worse outcomes.

We have made editorial changes to the guideline to emphasise this advice.

For detailed advice on how to conduct a multidisciplinary individualised risk assessment for a particular patient, we have recommended the recent international consensus statement: El-Boghdadly et al., "Timing of elective surgery and risk assessment after SARS-CoV-2 infection: an update", *Anaesthesia* 77:5 (May 2022).

Removed separate recommendation for vaccinated patients with "breakthrough" SARS-CoV-2 infection

We have removed our separate recommendation for surgical delay for vaccinated patients with breakthrough infection. Earlier in the pandemic, it was thought this category of patients might prove to have a specific risk profile, but this has not been supported as more evidence emerged. We now recommend that surgery in these patients is delayed on the same basis as any other infected patient.

Determining whether patients are still infectious

We have noted new evidence that rapid antigen tests (RATs) may be useful inside 90 days of infection, and emphasised seeking infectious disease expert advice when in doubt.

We have removed a distinction between omicron and other variants for determining when patients with mild/asymptomatic infection are no longer infectious.

We have also added new advice on infectiousness of immunocompromised patients – these patients may have an extended period of infectiousness of 20 or more days. Decisions for these patients should be made using a combination of time since infection, testing with either RAT or nucleic acid amplification test (NAAT), symptom monitoring, and infectious disease specialist advice.

For the full list of changes to this edition, please see the change log at the end of the guideline.

New evidence will be available soon, as *COVIDSurg*-3, an international study of 30-day mortality of patients with perioperative SARS-CoV-2 infection since the emergence of the omicron variant, is to be published shortly. We expect to release a new edition of this guideline afterwards. Therefore, as always, before making use of this document, please check you have the latest version via the college website.

Thank you to the SARS-CoV-2 Surgery Guideline Working Group members Dr Vanessa Beavis, ANZCA President 2020-2022, Past ANZCA President Professor David A Scott, Perioperative Medicine Special Interest Group Chair Dr Jill Van Acker and Dr Joreline (Jay) Van Der Westhuizen for developing the document, and ANZCA's representative on the National COVID-19 Clinical Evidence Taskforce, National Guidelines Leadership Group, Professor Paul Myles, who joined the working group for the second edition.

We invite suggestions and contributions for future versions, via email to sq@anzca.edu.au.

Anaesthesia-related deaths

Emergency laparoscopic appendectomy

The New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) has been reviewing deaths associated with anaesthesia and sedation since 1960. Example cases from the 2019 Special Report are being reproduced in the *ANZCA Bulletin* in an effort to enhance reporting back to the medical community. All fellows of the college are encouraged to read the SCIDUA report in its entirety. The detailed cases and data analysis presented are paving the way forward to a more informative and educational mortality analysis in New South Wales.

CASE 8: GENERAL SURGERY

A male in his early 20s presented for emergency laparoscopic appendectomy.

Background history:

Occasional smoker and childhood asthma.

The patient presented to hospital with a two-day history of feeling unwell/nausea and right iliac fossa (RIF) pain.

Anaesthetic details:

The patient was induced with a modified rapid sequence. Midazolam 2.5mg, Fentanyl 100 µg, Propofol 200 mg and Rocuronium 70 mg. The operation proceeded uneventfully and was completed in 30 minutes. Intraoperatively the patient received Cephazolin, parecoxib and ondansetron and a further dose of fentanyl.

The patient was transferred on to a bed and sat upright in preparation for extubation. He was suctioned and breathing spontaneously and opening eyes to command. Sugammadex 400 mg was given and the patient extubated.

Almost immediately post extubation the patient was noted to have an audible wheeze and started to desaturate. Bag mask ventilation was attempted, but despite high peep applied through the circuit ventilation was not possible. Oxygen saturations were 20 per cent and the patient lost consciousness. An arrest was called and the patient reintubated easily.

Salbutamol was delivered through the endotracheal tube and Adrenaline 0.5 mg intramuscularly and then 100 µg intravenously.

CPR commenced with the rhythm being PEA. The endotracheal placement was confirmed with a C-MAC as ALS (Advanced Life Support) continued.

Pink frothy sputum was noted in the endotracheal tube and suctioned. Nineteen minutes later there was return of spontaneous cardiac output.

Cisatracurium 50 mg and Hydrocortisone 200 mg were given. A chest x-ray revealed diffuse air space changes consistent with pulmonary oedema.

The patient was transferred to ICU but unfortunately did not show any signs of neurological recovery. A nuclear medicine scan confirmed no cerebral perfusion. The patient died seven days later.

Serial Mast Cell Tryptases were 3.6 µg.L, 2.3 µg/L and 2.3 microg/L (Done at time 0, 4 hours and 24 hours respectively)

Learning points

- The exact cause of this patient's death remains unknown.
- Clinically it sounds very much like anaphylaxis.
- The other possibilities such as aspiration and negative pressure pulmonary oedema could be considered, but usually are not accompanied by such abrupt cardiovascular collapse.

Source

Clinical Excellence Commission, 2021. Activities of the Special Committee Investigating Deaths Under Anaesthesia, 2019 Special Report. Sydney, Australia. SHPN: (CEC) 210176; ISBN: 978-1-76081-648-3.

Medication errors reported to webAIRS

IN DECEMBER 2021, an analysis of medication errors during anaesthesia in the first 4000 incidents reported to webAIRS was published in the journal *Anaesthesia and Intensive Care*[1].

This followed a previous article which presented a cross-sectional overview of the first 4000 incidents[2] where the reporters to webAIRS coded almost 17 per cent of the incidents as related to medications. It should be noted that this overview included a number of incidents which did not involve a patient or were an adverse reaction to a medication without error, or where a medication was used to rescue a patient, or the error did not reach the patient (potential hazards and near misses).

In the 2021 analysis 462 (10.6%) of the 4000 incident reports to webAIRS were identified as a medication error which reached the patient. The most common error category was incorrect dose (29.4%), followed by substitution (28.1%), incorrect route (7.6%), omission (6.5%), inappropriate choice (5.8%), repetition (5.4%), insertion (4.1%), wrong timing (3.5%), wrong patient (1.5%), wrong side (1.5%), and others (6.5%)[1].

A previous study using facilitated incident reporting in 2001 found that one drug administration error was reported for every 133 (0.75%) anaesthetics conducted. The two largest individual categories of error involved incorrect doses (20%) and substitutions (20%) with IV boluses of drug. Of the IV bolus substitutions, 69% occurred between different pharmacological classes[3]. Studies based on observation have shown much higher rates even than those using facilitated incident reporting.

While webAIRS does not collect denominator data for all the incidents collected, it is evident that medication errors during anaesthesia are consistently occurring, with a pattern of errors similar to previous studies.

The latent factors for medication errors can be divided into patient factors, task factors, caregiver factors and system factors. Root cause analysis often focuses on the human factors whereas there are often distractions and other contributors associated with the task or patient. System factors such as look-alike ampoules and similar packaging have been present since the landmark Australian Incident Monitoring Study (AIMS) article in 1993's The "*Wrong Drug" Problem in Anaesthesia*[4]. This article stated "Factors which contributed significantly to the incidents were similar appearance, inattention, and haste. 'Failure of communication' was a significant factor in syringe incidents when two or more staff were involved.

The only significant factor which minimised the outcome was rechecking of the syringe or drug ampoule before giving the drug[4]." Other system factors for medication errors include the current variability in the methods for the safe dispensing, storage, and the administration of medications.

There have been many recommendations and suggestions for improvements in the safety for administration of drugs including the "Five rights of medication safety". However, it has also been pointed out that the "Five rights of medication safety" are an aspirational goal rather than a method for achieving that goal[5]. This allows for unlimited interpretation of the necessary processes to achieve that goal at both an individual and an institutional level. With this level of variability, it is highly likely that the goals desired will not be universally achievable without substantial consideration of the work system in which drug administration happens.

What is required is a work process improvement at both an individual and an institutional level to address the human factors and the system factors that have led to what might be regarded as an unsafe work environment.

How can we improve at an individual and institutional level?

ANZCA *PG51* is a useful resource to assist with the safe administration of drugs[6]. Bar code scanners and other means of cross checking are both effective but involve additional costs to the organisations providing healthcare. At an individual level the "Stop before you block" method is useful to cross check before performing a regional procedure[7].

Practitioners could consider a similar approach of stopping and cross checking before any administration of a medication. This could either be performed in conjunction with your anaesthetic assistant or another colleague. In the event that no extra person is available a one-person cross check could be performed (one person checking twice) or a device such as a bar-code scanner could be used to assist.

A comprehensive set of interventions to improve medication safety are listed and discussed in chapter nine of a recent book *Medication Safety during Anesthesia and the Perioperative Period* published in 2021[8]. The authors are Professor Alan Merry who was an inaugural member of the Australian and New Zealand Tripartite Anaesthetic Data Committee and Professor Joyce Wahr, a member of the Anesthesia Quality Committee at the University of Minnesota Medical School.

The strengths of various interventions to improve patient safety are listed in table 9.1 in the book until the headings "Weaker actions", "Intermediate actions" and "Stronger actions". Many of the current methods to prevent medication error such as double checks, warnings and labels, new procedures, memos or policies, and additional studies or analysis are in the weaker column.

This is not because they are not important, in fact it is quite the reverse. We already do these well, but errors still occur due to various human factors such as distractions, as well as the various latent factors that still exist in the system.

Intermediate actions include checklists, cognitive aids, electronic and software enhancements, increased staffing or reduced workload, enhanced communication techniques such as "read back", elimination of look-alike and sound-alike medications, separation of dangerous medications such as KCl from routine medications and elimination or reduction of distractions. Stronger actions include architectural or physical

changes to the workplace, leadership in support of patient safety, simplification of the work process and removal of unnecessary steps, standardisation of equipment and process of care mapping, testing of new devices before purchase and forcing functions such as the pin index system on cylinders[8].

In general, interventions become more costly as they become stronger which often leads to choices in the weaker category after root cause analysis of the errors at individual institutions. In other words, intermediate and stronger actions are more difficult and more expensive. As indicated, the organisational context is critically important, and success is more likely if there is strong alignment between institutional leadership and the clinicians at the workface.

A strategy to make significant change could occur in two steps. The first would be to immediately adopt some of the easier but weaker interventions coupled with a second longer-term plan to implement stronger interventions in the context of a whole-of-organisation initiative to improve medication safety. It would be important to keep the stronger intervention in the forefront of future planning for the organisation and not forget about it until the inevitable next failure of the current work processes.

The conclusion for the 2021 WebAIRS study was "that medication error in anaesthesia is an ongoing and pervasive problem which often results in patient harm. The wide variation in the nature of the errors and contributing factors underlines the need for a systematic response to improving medication safety in anaesthesia, underpinned by a focus on culture. This is long overdue and will require a concerted and committed engagement of all concerned, from practitioners at the clinical workface, to those who fund and manage healthcare[1]."

The full text of article is available via the Anaesthesia and Intensive Care website and the ANZCA library.

ANZTADC Case Report Writing Group

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DECLARATION OF CONFLICTING INTERESTS

The authors have declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article:

- Alan Merry has financial interests in Safersleep LLC, and is a co-author of several of the publications referenced in this paper.
- Craig Webster is a minor shareholder in SaferSleep LLC and a co-author of several of the publications referenced in this paper.
- Martin Culwick is the Medical Director of ANZTADC and a co-author of several of the publications referenced in this paper.

The remaining authors in the ANZTADC Case Report Writing Group are members of the ANZTADC committee but do not have any other conflicts of interest to declare regarding this publication.

Lessons on how to live with long COVID

Melbourne anaesthetist Dr Suzi Nou, the immediate past president of the Australian Society of Anaesthetists, contracted COVID-19 earlier this year. Here, in a question and answer session with the *ANZCA Bulletin* she speaks candidly about her recovery and the impact of long COVID.

How has your experience affected your approach to the specialty, your clinical work and the measures you take to prevent infection?

For a month while I was awaiting a cardiac magnetic resonance imaging (MRI) scan, the working diagnosis was post-COVID myocarditis as my trans-thoracic echocardiogram was normal. The intermittent chest pain I was experiencing was a distraction and I didn't want to compromise patient care. I've always appreciated the great deal of responsibility we carry when we are in theatre and the timing of my chest pain during a working day reinforced this. As a result of time away from theatre, I enjoyed a deeper practice of perioperative medicine and enjoyed my ongoing work with our COVID Community Team.

Since the outset, I have tried to prevent infection with SARS-CoV-2. We are still learning about all the problems that are due to COVID. I find the current messages about individual responsibility and the encouragement to go about our usual lives troubling and conflicting with the daily death toll from COVID. If we continue at our current rate, we can expect 15,000 deaths due to COVID in Australia this year, which will place it second to coronary heart disease as the leading cause of death[1].

Although I have made a full recovery, I am not keen to be infected a second time. As much as possible, I follow the ongoing Victorian public health recommendation to wear a face mask in indoor settings. John Snow was an anaesthetist and epidemiologist who identified that contaminated water was contributing to the cholera outbreak in London in the 1850s. There have been many accomplished scientists and doctors (and anaesthetists among them) who have identified the airborne transmission of SARS-CoV-2. It is with some urgency that I think we need to address indoor air quality in Australia.

Research into long COVID is still in its infancy and you have noted from your own experience that while you were diagnosed with long-COVID and pericarditis, others have been frustrated by their misdiagnosis and lack of acknowledgement of their symptoms. How crucial is it for research funds to be dedicated to this little known area of research?

I was relieved when the World Health Organization developed a clinical case definition for post COVID-19 condition in October last year[2]. Hopefully this has helped advance research in this area. Ultimately, most people with ongoing COVID sequelae are looking for treatment so that they can return to some level of function. There is much more work to be done in this area and research funding is crucial to support this.

How important was it for your recovery to have not only your family but your colleagues in public and private practice acknowledge that long COVID is a medical condition that needs to be carefully managed and treated?

My family were completely supportive of me stepping back from clinical duties. My husband is also a medical practitioner and was aware of the study which reported almost twice the rate of sudden cardiac death in the first 12 months following COVID. My private practice group and surgeons that I work with were also very supportive. I work in a large public hospital department with over 60 anaesthetists. Everyone who was aware was very supportive. We were desperately short staffed at times and I could see that it was a balance of providing a clinical service as well as colleagues not wanting to breach confidentiality about my condition. I was very impressed with how those who knew would step in at just the right times.

"I've been surprised how many people have come forward with their post-COVID conditions: trigeminal neuraliga, thyroiditis, migraines, and then the ones harder to label such as fatigue and brain fog."

You have spent years working on the hospital frontline. How did this prepare you for your admission to a cardiac unit for tests, unsure of what your diagnosis would be after you had experienced severe chest pains?

I found it reassuring that I didn't have severe COVID and was out of that danger period of the intitial two weeks. My chest pain had always been mild and I barely called it pain. At first I thought it was a lot of fuss, until I saw my ECG, which had been essentially normal a few weeks prior. My concern was more for my ongoing rehabilitaion, particularly if it was myocarditis and the risk of deterioration if I am infected again. The coronary care unit stay was very restful and I was impressed by the care I received. I felt too well to be a patient as I mingled with the other patients, doing their post-operative rehabilitation and carrying their chest drains. At one point I swapped my patient hat and returned to being an anaesthetist as I assisted a patient with anaphylaxis in the computed tomography suite, but that's a story for another time!

Can you identify any positives from your experience with long COVID that can help us understand more about the condition?

Since speaking about this openly, I've heard from others who have been grateful and really appreciated knowing my thought process as I stepped away from clincial work. Hopefully this reduces stigma towards chronic illness and the need for presenteeism that we experience in medicine.

In terms of COVID, I've been surprised how many people have come forward with their post-COVID conditions: trigeminal neuraliga, thyroiditis, migraines, and then the ones harder to label such as fatigue and brain fog. Some of these have developed when there was no documented COVID infection, which was revealed on subsequent testing. My suggestion now is that if people develop a new condition but haven't had COVID, to seek testing for prior COVID infection with serology and nucleic acid tests – particularly if there was an episode of COVID-like symptoms. They might have had COVID that wasn't detected at the time and this new condition could be associated.

Finally, what advice can you give to anyone, including clinicians, if they believe they may have long COVID?

In my work as a COVID community doctor, I encourage all my patients with moderate or severe COVID to follow up with their GP in the weeks after they have recovered. A common symptom of COVID and long COVID are mood changes such as depression and irritability and GPs can really help in this area. On that note, I want to emphasise how commonly the central nervous system (CNS) is involved with acute COVID. Fatigue, headache, loss or change in smell or taste and reduced visual acuity are all symptoms of CNS infection. I'm not sure of the evidence in this advice but I recommend people with COVID to rest if they have CNS involvement, similar to how they might rest their brain after a concussion. I found I had to rest from exercise during and following COVID and I suspect similar rest might reduce the impact and benefit recovery from CNS involvement to a degree. If the symptoms continue, then I encourage seeing your GP.

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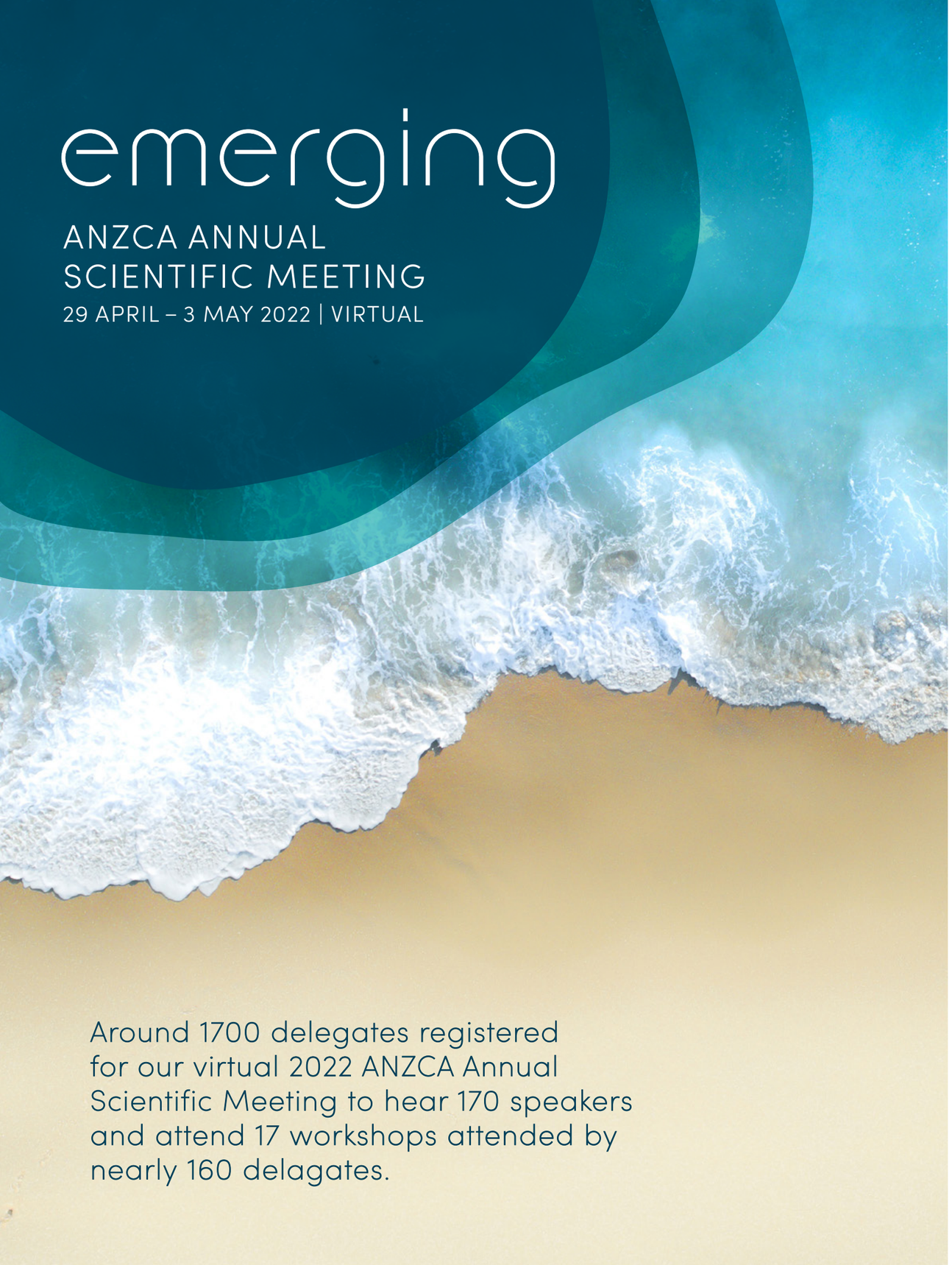


Around 1700 delegates registered for our virtual 2022 ANZCA Annual Scientific Meeting to hear 170 speakers and attend 17 workshops attended by nearly 160 delagates.

ASM emerges as a virtual meeting

The 2022 Perth ANZCA ASM had its origins "Emerging" back in 2018. Initially envisioned as the 2020 Perth ASM, we delivered the second ever fully virtual ANZCA ASM. Created and developed in Perth, produced and delivered from Adelaide, streamed across Australia and reaching delegates in Spain, the United States, United Kingdom and even further afield, this was surely a meeting for the times.

If ever there was a story of ups and downs, the 2022 ANZCA ASM would fit the bill. From the disappointments of cancelling the 2020 ASM and having to pivot to a fully virtual meeting only eight weeks out, to the highs of far exceeding our targets and delivering an exceptional meeting. This has certainly been a journey to remember for all members of the regional organising committee (ROC), the ANZCA Events team and the college itself.

After setting ourselves a target of 1200 delegates, there were more than 1700 registered delegates. Eighteen sold-out workshop sessions on the Friday, together with record numbers for the Faculty of Pain Medicine sessions, the ASM certainly got off to a flying start. Our opening plenary session had approximately 700 delegates watching online. Unique and inspiring sessions such as "Walking the line: Tales from the OR" and the "TED-inspired sessions" proved to be extremely popular setting social media and the event platform alight, with great discussions generated by delegates.

The ASM delivered seven plenary sessions (21 lectures), 12 STAT sessions (36 discussion panels), seven breakout sessions including three poster sessions as well as exciting new research presented by fellows and trainees. The Gilbert Brown Prize session, always a highlight on the ASM calendar, again showed us that the future of ANZCA-led research is in bright hands. With more than 17.6 million impressions, 3500 tweets and a potential audience of 1.3 million people reached through print, radio and television the impact of anaesthetists was certainly on display over the five days of the meeting.

Delegates were both educated and entertained by a range of quality keynote speakers from Australia and overseas. I believe the ASM has shown us that the way future scientific meetings are presented has irrevocably changed. That said, having the option to meet in person again is something we all hope for as we look forward to Sydney 2023.

To the ROC of the 2022 Perth ASM, well done on an amazing effort. It has been a privilege working with you all on this project. Thank you also to Dr Pavla Walsh and Dr Brian Hue for their work on the very successful ASM FPM program, and Dr Chui Chong and Dr Alison Kearsley who did an outstanding job as convenors of the FPM Symposium that preceded the ASM. We have delivered an exceptional meeting that has held its own among its predecessors. To the committee members from 2020, thank you for your contributions during the time you were involved. To ANZCA and the Events team, again a big thank you for your support over the long journey.

Finally, to Dr Tanya Selak, Dr Shanel Cameron and the 2023 Sydney ROC, good luck! We are all hoping that you can deliver the first in-person ASM in four years.

Dr Neil Hauser
ASM 2022 Convenor

Top takes from the 2022 ASM

Engagement leader board winner, Dr Anna Shirley FANZCA from Toowoomba Hospital in Queensland tells us about her favourite top five.

1

Challenging airways and locations

Professor Ross Hofmeyr, South Africa

Ross has a very refreshing presentation style that made the presentation very relevant and memorable!

2

Can we manage without nitrous in paediatrics?

Associate Professor Justin Skowno, NSW

As an anaesthetist with an interest in both a paediatric anaesthesia and environmental sustainability, this touched on both very well. Justin also is able to back up this talk with easy-to-understand facts, as well as extensive experience. memorable!

3

CS09 Environment and sustainability

This panel helped to make me feel reinvigorated in trying to find ways of "doing more", in regard to perioperative sustainability in our regional hospital, and also to gain new 'alliances' with like-minded people in other hospitals

4

Why perioperative IV iron doesn't work: A deliberately inflammatory presentation

Associate Professor Lachlan Miles, Vic

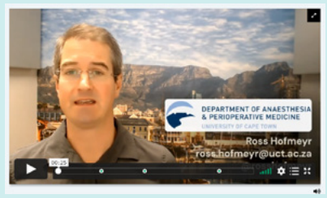
This was great food for thought. It was very topical and well presented.

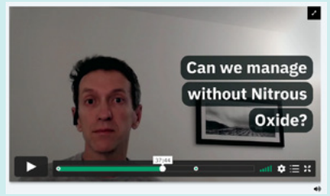
5

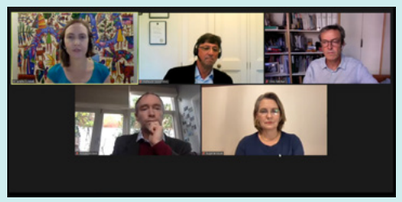
The surgical approach has changed, should we change the anaesthetic? Reverse total shoulder and anterior hip arthroplasties

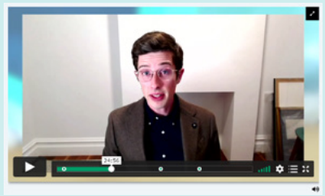
Dr Chris Mitchell, WA

This was a great way at looking at improving patient safety, especially with total knee replacements, and maximising outcomes, while encouraging greater patient health literacy to take ownership of their reversible risk factors prior to coming for surgery.









ASM 2022 media coverage

Raising our profile

ANZCA 2022 ASM and FPM Symposium presentations featured in the media throughout the meeting.

The coverage was spread across all three mediums (print, online and broadcast) and reached a potential audience reach of nearly two million people.

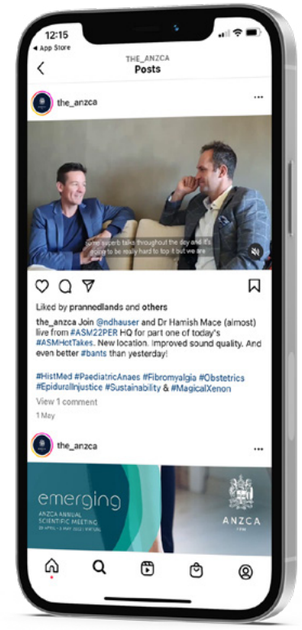
ANZCA media releases were distributed throughout the meeting and the media coverage was kicked off by FPM Dean Associate Professor Michael Vagg previewing the FPM symposium on 2SM Sydney radio news bulletins on Friday 29 April.

Print articles in the *Herald Sun* by medical editor Grant McArthur and syndicated to the *Sunday Tasmanian* about trainee anaesthetist Dr Vivian Liang's study of sleep disturbances in children for which she was awarded the ANZCA Trainee Research Prize featured on Sunday 1 May reaching nearly 800,000 readers.

Dr Ian Maddox's "epidural injustice" special interest group obstetric anaesthesia session on Sunday 1 May was previewed as an exclusive page 3 report "Perth anaesthetist Ian Maddox says women in childbirth not being prioritised properly for pain relief" by journalist Kate Emery in the *WA Sunday Times*. The article was also syndicated to another 16 WA online news outlets including the *Kalgoorlie Miner,* the *Bunbury Herald,* the *Broome Advertiser* and the *Albany Advertiser* and reached a combined print and online audience of more than 700,000 people.

ABC Radio news reports on Wednesday 4 May in several Australian states featured nearly 40 audio news "grabs" of Professor Kate Leslie being interviewed about her gender in medical research presentation on the final day of the ASM. The news segments were included in news bulletins in Sydney, Melbourne, Brisbane, Perth, Adelaide, Hobart, Canberra, Darwin, Alice Springs, the Gold Coast and Newcastle.

Other ANZCA media releases announcing the new ANZCA and FPM leadership and the latest research findings from the POISE-3 clinical trial were also distributed.



Social media at the ASM

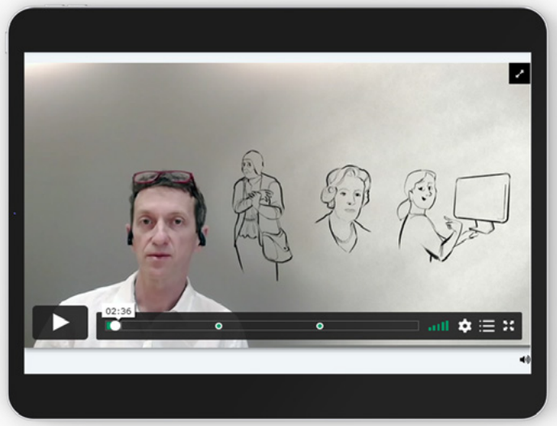
As a fully virtual ASM, social media played a big role in allowing you to connect, spark conversations and share some of your best bits from the meeting.

On Twitter, the #ASM22PER hashtag had over 17.6 million impressions, almost 3500 tweets and over 300 participants. Some of the sessions that really got your thumbs moving included the "Media in medicine", "Walking the line: Tales from the OR", "Inform, inspire, influence talks", "Reflections on trainee leadership through adversity", and the "ANZCA late breaking trials" sessions. The hashtags #ASM22pets and #ASM22wellbeing let you share your furry and feathered friends keeping you company during sessions and what you got up to in the breaks to recharge.

We chatted to convenor Dr Neil Hauser and scientific co-convenor Dr Hamish Mace daily about their ASM "hot takes" over on our Instagram. They gave us the lowdown on the top sessions from the program, which you can go back and watch onDemand. We also shared video interviews and a few snippets from some of the major sessions. We've created a handy one-stop-shop playlist with all of these videos on our YouTube.

We live-streamed the closing plenary to our Facebook page which included award presentations of the Gilbert Brown Prize, ANZCA Trainee Research Prize, ANZCA Trainee Quality Improvement Prize, Trainee ePoster Prize and the Open ePoster Prize. It also included Dr Amanda Gimblett and Dr Sally Ure's talk "Te Whare Tohu o Te Hau Whakaora – naming ANZCA", Dr Susie Lord's talk on "Reconciliation – ANZCA in action" plus the ANZCA President handover and closing address with Dr Vanessa Beavis and Dr Chris Cokis.

Bringing ideas to life at the ASM



Associate Professor Justin Skowno from Sydney began his search for presenter and audience-friendly software after finding he was "allergic to PowerPoint". He didn't like the format or the engagement it seemed to actively avoid. He then discovered Prezi, a presentation software platform, and became one of its early adopters.

That was back in 2010 but he, like other early users of the motion landscape format, found it had its drawbacks.

"I probably made a few people sick with those first presentations, but I also got a lot of good feedback. On my first big conference in the US, I got more comments on the style of presentation than the content which was slightly galling for the scientist in me!", Dr Skowno explained.

Prezi presentation software has evolved. It still has motion, zoom, and spatial relationships to bring ideas to life but it has now added video to the platform.

Presentations by Dr Skowno and South African anaesthesiologist Dr Ross Hofmeyr who both made good use of the software to bring their talks to life got many people talking at the ASM. However, Associate Professor Skowno took this one step further with captivating real time graphics during his Mary Burnell lecture "From mere survival to thriving. Progress in paediatric anaesthesia from 1842 to 2042."

"Professor Kate Leslie had told us once about employing an artist for diagrams and illustrations, and this got me thinking. Blue Mountains artist Bill Hope did an amazing job with the sketches. Yes, it cost but this was a one off special and it was all worth it."

**Check out a quick 101 presentations tutorial from Dr Skowno on our social media channels.*

It's not too late to register!

You can access 80+ hours of scientific content from the 2022 virtual ANZCA Annual Scientific Meeting (ASM) and FPM Symposium until May next year by registering before Friday 29 July.

Emerging leaders share insights for 2022

THE 2022 ANZCA Emerging Leaders Conference (ELC) was held virtually from 26-28 April with the theme "Reflect, Evolve, Achieve."

Twenty-five anaesthetists and pain medicine specialists from Australia, New Zealand and Papua New Guinea were invited.

While planned as a face-to-face event, the conference was adapted to a virtual format due to the delayed Western Australian border reopening and the uncertainty of COVID. This meant planning for pre-recorded presentations, adequate break times and ways to encourage networking. Our aim for the conference was to share different and broader perspectives on leadership with delegates, explore challenges that are faced locally, regionally and internationally, and give insight into how delegates could expand their leadership style. Leaders from ANZCA, FPM, other medical specialties and business fields were invited to share their knowledge and experiences. Our mentor groups were another popular initiative following their success at the 2021 ELC.

Day one began with discussions on what delegates viewed as good, and not so good, leadership traits, to then tackling management challenges that heads of department or directors would potentially encounter. Next up was an informative panel discussion with Dr Fiona MacFarlane, Dr Anna Miedecke and Dr Alex Swann outlining their experiences with the challenges they faced, what they've learnt since and their views on leadership. Delegates then explored different aspects of feedback conversations with Dr Kara Allen and Mr Maurice Hennessy.

At the end of day one, Dr Curtis Walker joined us for a fireside kōrero to share his experience advocating for Māori health equity, his personal journey from a family of medical practitioners, and where he sees opportunities for change. Dr Rachel Farrelly, a Gunu Gunu woman who will become Australia's first female Aboriginal surgeon then shared her experiences as an indigenous person from rural NSW, how she was supported to pursue orthopaedic training, and the adversities she has overcome. There were invaluable lessons on how we can all champion Aboriginal and Torres Strait Islander health equity in Australia.

On day two we learnt about managing teams, personalities, performance and how to manage burnout from entrepreneur and businesswoman, Mrs Sue Pember. Following this, Professor Kirsty Forrest taught us how to uncover our own biases and demonstrated how they impact our frameworks and decisions. It was then time for a change of pace with Associate Professor Asha Bowen sharing her experiences as a clinician scientist, her research into evidence-based skin infection in Aboriginal and Torres Strait Islander children, and how she pivoted for COVID. Mr Amos Roach then guided us through a narrative of healing through music and meditation, which was a highlight of the conference. Day two wrapped up with a cocktail and mocktail masterclass.

On the final day we heard from Dr Tania Rogerson on leadership lessons from her career and Dr Maryann Turner shared a global leadership perspective including her experience as a lawyer in the NSW Supreme Court and working in the UK when COVID first hit. Dr Chris Cokis then chaired an engaging panel on challenges facing our specialties in the future featuring Dr Vanessa Beavis, Associate Professor Mick Vagg and the presidents of our international sister colleges in Malaysia, Singapore and Hong Kong. The conference concluded with a speed dating-style session which received great feedback.

Thank you to all our delegates, mentors and speakers. We hope you found this experience as enjoyable as we did and gained some key insights to continue evolving your leadership journey.

Dr Charlie Ho and Dr Nirooshan Rooban
2022 ELC Co-Convenors

Steuart Henderson Award 2022: Dr Joel Symons

AFTER GRADUATING IN science and then medicine from the University of the Witwatersrand, Johannesburg, South Africa, Dr Joel Symons undertook his anaesthesia training at the Alfred Hospital in Melbourne, obtaining FANZCA in 2005. Working with Professor Myles, he established a university-based short course (2009) and Master degree (2013) in Perioperative Medicine - the first of its kind in the world.

His influence in education is far-reaching. Realising that perioperative medicine, and indeed education, is multidisciplinary and collaborative, he was a founding board member of the International Board of Perioperative Medicine, which aims to standardise perioperative medicine education internationally. In 2020, he set up a joint online short course in perioperative medicine delivered by Monash University and University College London. This course aims to bring cost-effective perioperative medicine education to low and middle income countries, with participants from over 30 countries.

As Chair of the ANZCA Perioperative Medicine Education Group, he is leading the development of a curriculum and resources for the ANZCA Perioperative Medicine Diploma commencing in 2023. He is also a member of the executive of the ANZCA Perioperative Medicine SIG and Perioperative Medicine Steering Committee.

Apart from his extensive experience in developing educational content, he is a regular presenter on perioperative medicine education both locally and internationally and is a mentor to others who are developing online educational resources. Invited presentation include "A future career in Perioperative Medicine" for the Royal College of Anaesthetists meeting in London, May 2018.

Dr Symons is clearly a world leader in anaesthesiology education. He has brought credit to our college.

Professor Paul Myles

"Dr Symons is clearly a world leader in anaesthesiology education. He has brought credit to our college."

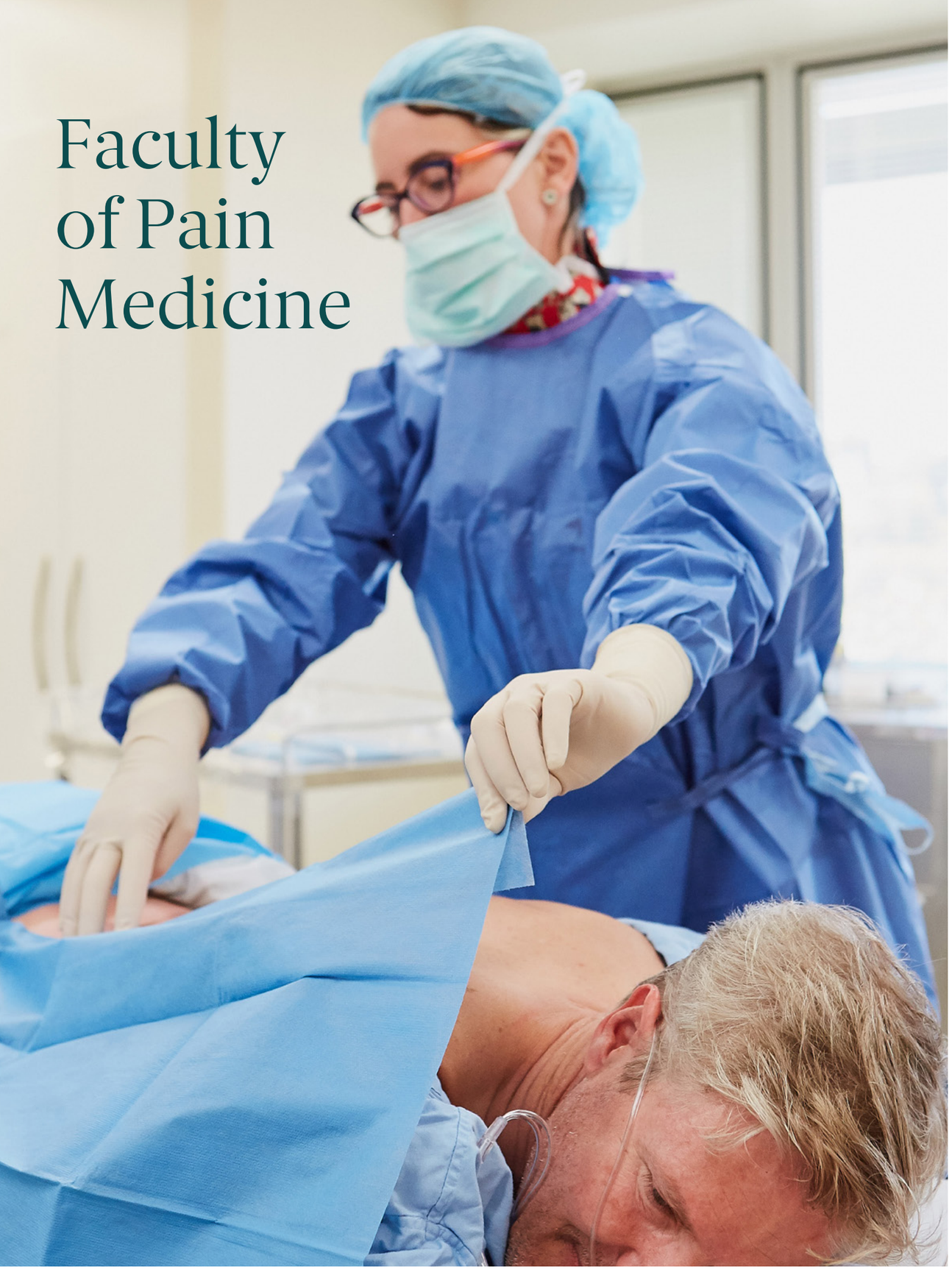
ANZCA
FPM

Call for 2023 Steuart Henderson Award nominations

Nominations are being received for the 2023 ANZCA Steuart Henderson Award: awarded to a fellow who has demonstrated excellence and provided outstanding contribution, scholarship and mentorship to medical education in the field of anaesthesia and/or pain medicine. All fellows of ANZCA and FPM are eligible for the award.

For nomination information including eligibility criteria visit the ANZCA website.

Nominations close 15 February 2023.



Faculty of Pain Medicine

Dr Kieran Davis takes over as dean

"This is a fascinating time to be taking over stewardship of the faculty, with face-to-face meetings and conferences starting again."

ONE OF THE many impacts of the pandemic has been that we have not been able to meet and get to know each other so I am going to start my first dean's message by talking about myself. I am originally from Stoke-on-Trent in the UK, which has left me supporting lower league football for most of my life.

From there I went to medical school in Leeds and after my house officer jobs, I came to New Zealand where I first experience this beautiful country I now call home. It was also my first experience of pain medicine at Burwood hospital.

I returned to the UK where I did my anaesthesia training and became the father of three wonderful now grown-up children, but the desire to return to New Zealand led me to getting the pain fellowship position here in Auckland and as they say the rest is history.

This is a fascinating time to be taking over stewardship of the faculty, with face-to-face meetings and conferences starting again. I am really looking forward to the faculty's Spring meeting in Noosa. With the theme "Better Together" it will be the perfect time to re-connect with colleagues while participating in a world-class meeting.

The FPM Board has changed a lot over the past couple of years and it is my pleasure to welcome Dr Noam Winter, Dr Michael Veltman and my friend and colleague Dr Leinani Salamasina Aiono Le Tagaloa. I would also like to welcome Dr Dilip Kapur who comes back on to the board as the vice-dean, and he has already hit the road running by chairing the Training and Assessment Executive Committee and providing me with his knowledge and wisdom around the working of the Australian healthcare system.

Following the lead of the former dean Associate Professor Mick Vagg I believe it is essential that the faculty continues to advocate for our fellows and our patients.

The failure of the previous Australian government to fully implement the Medicare Benefits Schedule review of pain medicine has taken significant resources out of our specialty and getting resolution to this is a top priority.

I also believe we need to create an advocacy plan around how we will engage with the health departments at both a state and federal level.

In New Zealand it is a pivotal time, the completion of the models of care (MOC) done in conjunction with the Ministry of Health coincides with the restructuring of healthcare delivery across the country.

Our hope is that pain medicine will be a core specialty that must be provided by all the new health funding authorities and from there we can work to implement the MOC across the country.

I hope you are all heading into winter with your work and personal lives returning to normal. I have personally enjoyed meeting patients and colleagues face-to-face once again.

I hope to meet as many of you as possible in either Noosa in October or at one of our other meetings over the next two years.

Dr Kieran Davis
FPM Dean

Thanks to a dedicated leader

IT IS MY PLEASURE on behalf of the fellowship, the board, the executive director and faculty staff to thank Associate Professor Mick Vagg for his dedication, hard work and leadership of the Faculty of Pain Medicine over the past two years.

When Mick took over the role of dean of the faculty in May 2020 we were all in the early stages of the COVID-19 pandemic and at that time we did not know that we had the lengthy Melbourne lock downs ahead and that the faculty and college would be working from home for the majority of his two year term. But to quote Mick's favourite poet, Robert Frost, "in three words I can sum up everything I've learned about life: it goes on", for Mick this should read "it Zooms on". During Mick's time as dean we have only had one face-to-face board meeting and that was in April 2022. Every other meeting of the board, the FPM executive and all our committees have been by Zoom; despite this Mick did not just hold the fort, he continued to grow the faculty and lead it forward.

The faculty has flourished under Mick's leadership. Stronger engagement with government through representations at state and federal level, including a meeting with Federal Health Minister Greg Hunt, has raised the profile of the faculty as a valued advisor. The key strategic goal over the last twelve months has been to convince the Federal Government to fully implement the MBS review, to this end Mick has met not only the Federal Minister but also the Parliamentary Friends of Pain Medicine to get the best possible outcomes for our specialty. Mick has placed advocacy as a key strategic goal for the faculty and leaves us well placed to push for better access to and funding of pain services across New Zealand and Australia.

Mick formed a formidable team with ANZCA's immediate past president Dr Vanessa Beavis, and progress has been made on his watch around the internal workings of the board and its relationship with ANZCA Council. Reports from council are that Micks perspectives as a Specialist Pain Medicine and Rehabilitation Physician provided alternative insights into complex issues. Our new Executive Director, Leone English, sits within the ANZCA Executive Leadership Team providing a clear voice at the top tables of ANZCA.

Mick has also worked with our ANZCA colleagues to create the new DPA education role which will give us the opportunity to refresh our training program and maintain it as the leading pain medicine training program in the world.

The signature achievement of Mick Vagg which he drove from concept to implementation is the Procedures Endorsement Program (PEP). Prior to this program procedures in pain medicine were an area that the faculty claimed jurisdiction over but provided limited training and professional standards around. It was Mick who brought this to the Board and insisted that we had a professional obligation to provide training in pain medicine procedures. He then led the creation of the clinical care standards and then utilised the entrustment concepts to develop the endorsement program; which in itself is an elegant way of creating a training process without a separate fellowship. Through the PEP the faculty is again leading the world and moving the boundaries around what is best practice.

In his term as dean Mick has revelled in the social media world; anyone who doesn't follow @teddytingley should do so, his wit and enthusiasm in tackling complex issues in 280 characters is legend. He has also been prolific in all forms of the media including his excellent article in the UK Guardian within their chronic pain series as well as interviews on the ABC and the creation of web platform for pain medicine advocacy groups.

Anyone who knows Mick will know him as an approachable and sociable leader, who is an avid conference organiser and attender, and it is a tragedy that his warm and engaging persona has been limited to Zoom. I am therefore delighted that Mick will serve on the faculty board for two more years and will provide ongoing leadership for the faculty as the Chair of the Procedures Endorsement Program.

As a friend and on behalf of the fellowship and staff of the faculty, I would like to thank him unreservedly and salute his enormous legacy built on dedication and professionalism of the highest order, and I hope to be able to spend the time with him in person that we have not been able to over the last two years.

Dr Kieran Davis
FPM Dean

Changes to the FPM Board

Dr Dilip Kapur, Dr Noam Winter and Professor Michael Veltman were elected to the FPM Board following the retirements of Associate Professor Newman Harris and Dr Harry Eeman. Dr Leinani Salamasina Aiono-Le-Tagaloa was also co-opted to the board. Dr Scott Ma has been appointed the ANZCA councillor to the board.

WE FAREWELL

Dr Harry Eeman

Dr Harry Eeman was the first new fellow elected member to the FPM Board in 2017 and remained an elected member until May 2022. He has been heavily involved in the Learning and Development Committee, the curriculum redesign project and Blue Printing Subcommittee. He has been the FPM representative on the Perioperative Medicine Steering Committee and the Trainee Wellbeing project group. He is the supervisor of training at the Barbara Walker Centre for Pain Management at St Vincent's Hospital, Melbourne.

Associate Professor Newman Harris

Associate Professor Newman Harris has been a member of the FPM Board since 2013 and has held a number of key roles over the years. His leadership work as chair of the Examination Committee and overseeing the implementation the summative assessments within the 2015 curriculum was a significant achievement. He has been the FPM representative on the board of Painaustralia, a member of the Training and Assessment Executive, Education Committee and the ANZCA Hospital Accreditation Committee as well as a member of the Exit Questionnaire Subcommittee, Examination Advancement Advisory Group, and the Awards Working Group.

WE WELCOME

Dr Dilip Kapur

Dr Dilip Kapur is a specialist pain medicine physician and anaesthetist based in Adelaide. He has been appointed vice-dean, chair of the Training and Assessment Executive Committee and a member of the FPM Executive Committee and the ANZCA SIMG Committee.

He has broad experience of pain medicine through a long career in the discipline. His previous work with FPM and ANZCA has furthered his insight into the challenges that face both the college and the faculty.

Dr Leinani Salamasina Aiono-Le-Tagaloa

Dr Leinani Salamasina Aiono-Le-Tagaloa is a specialist pain medicine physician and anaesthetist based in Auckland. She is a member of the ANZCA New Zealand National Committee, an FPM examiner and member of the FPM Examinations Committee and was co-opted to the FPM Board in April 2022.

Professor Michael Veltman

Professor Michael Veltman is a specialist pain medicine physician and anaesthetist based in Perth. He is the chair of the Training Unit Accreditation Committee, an accreditation reviewer and a member of the Training and Assessment Executive Committee and the ANZCA ICT Governance Committee.

He is a procedural pain medicine specialist, with a strong background in a range of clinical areas including perioperative medicine and echocardiography. He is keen to further the role of the faculty in helping grow pain medicine as the definitive group for providing care and advice in pain management.

Dr Noam Winter

Dr Noam Winter is a specialist pain medicine physician and anaesthetist based in Melbourne. He is the FPM ASM Officer, an FPM examiner, chair of the Scientific Meetings Committee and a member of the FPM Professional Affairs Executive Committee and the ANZCA ASM and Events Planning Committee.

He is completing the Leadership for Clinicians course of the Royal Australasian College of Medical Administrators.

New fellows

We congratulate the following doctors on their admission to FPM fellowship through completion of the training program:

- **Dr Nicholas Aitcheson,** FAFRM (RACP), FFPMANZCA (Qld).
- **Dr Joel Champion,** FRACP, FFPMANZCA (NSW).
- **Dr Tejas Kanhere,** FRACGP, FFPMANZCA (NSW).
- **Dr Ern Ming Lim,** Masters in Anaesthesia – University of Malaysia, FFPMANZCA (Malaysia).
- **Dr Say Yang Ong,** MMed (Sing), FANZCA, FFPMANZCA (Singapore).
- **Dr Amutha Samuel,** FANZCA, FFPMANZCA (Vic).
- **Dr Anthony Sayce,** FRACGP, FFPMANZCA (NSW).
- **Dr Karen Wong,** FANZCA, FFPMANZCA (NSW).

PS12(PM)

The Faculty Board has approved *PS12(PM) Position statement on the use of ketamine in the management of chronic non-cancer pain* and its background paper after the close of the pilot phase and consideration of the feedback received. *PS12(PM)* reflects both the unsettled state of the literature in this arena and the fact that such practice is "off-label" in Australia and New Zealand. This document is not a guideline for the use of ketamine in chronic non-cancer pain but offers guidance in this controversial arena, based on the literature and expert consensus, in order to inform the judgement of practitioners and to promote safety and quality for their patients. The updated document is available on the college website.

Training unit accreditation

The following units have been accredited for pain medicine training:

- Concord Hospital (NSW).
- St Vincent's Hospital, Sydney (NSW).
- Sydney Spine and Pain (NSW).
- Pain Matrix Geelong (Vic).
- Queen Mary Hospital (Hong Kong).
- Wellington Hospital (NZ).

Advanced clinical skills course

The advanced clinical skills course was held on 14-15 May 2022. This was the first time the course had been held in person since 2019. This year the course was held both at Royal North Shore Hospital and via Zoom for participants who were unable to travel to Sydney with more than 40 trainees taking part.

Trainees were taught various skills including general physical examination, interviewing and formulation.

The faculty would like to thank Associate Professor Paul Wrigley for his leadership in organising the course. Special thanks also to Pam McLean Centre, Dr Martine O'Neill and Professor Milton Cohen for their continued contribution to the advanced clinical skills course.

Symposium success

IT HAPPENED FINALLY! On 29 April, we held the annual FPM Symposium with the theme of "Adapting" virtually. It was well attended with more than 230 registrants. IASP President, Professor Claudio Sommer discussed use of calcitonin gene-related peptide receptor antagonists (gepants) for migraine. Dr Delcanho updated us on use of Botox for oro-facial pain while Associate Professor Ramesh Balasubramaniam discussed various treatment options for Burning Mouth Syndrome.

Professor James Middleton provided updates from CanPain SCI clinical practice guidelines (2021) while Professor Steven Faux presented on various treatment options for enthesopathies and tendinopathies. Professor Fiona Wood illustrated nicely the use of multimodal approach to treatment of post-burns pain, emphasising the "answer is not always in the drug cupboard". Dr Lindy Roberts, Dr Nicole Liesis, and Professor Liz Molloy then explored challenging topics on "Gender in pain medicine", "Mentoring", and "Giving feedback". Our last session was dedicated to "Legacy patients and opioid crisis" with presentations from Professor Bart Marlion, Professor Moira Sim and Dr Richard O'Regan. This evoked lively discussions on use of opioids for chronic non-malignant pain in long term and great tips on how best to manage opioid legacy patients.

The sessions were recorded and will be available for up to 12 months until 30 April 2023. If you would like to listen to any of the topics above, you can still register before 31 July and gain access. Please visit asm.anzca.edu.au.

We would like to thank all the invited speakers, chairs and events team for delivering a great program which was truly multi-disciplinary with experts from pain medicine, anaesthesia, rehabilitation, surgeries, dentistry, emergency, neurology, addiction medicine and general practice! Many thanks also to Dr Pavla Walsh and Dr Brian Hue for being ASM FPM program co-conveners.

Dr Chui Chong and Dr Alison Kearsley
FPM Symposium Convenors

Top takes from the 2022 FPM Symposium

Dr Kamran Malick, an FPM trainee from the Royal Perth Hospital, has chosen three highlights from the symposium.

The virtual conference itself

I think it was a tremendous effort on part of FPM to organise an event of this size virtually. The event progressed without any glitches. The convenience of attending such vital educational meetings while keep safe and available for the community is vital.

Update on headache and facial pain

Professor Claudia Sommer

A very informative up-to-date lecture on headaches and orofacial pain syndromes. As a first-year trainee I found it very useful and applicable to my daily workings in the clinic with the addition of a literature review. It was very topical and well presented.

A background on legacy patients

Professor Bart Morlion

A real-time scenario that we are faced with in our day-to-day clinics and a holistic approach towards this underserved cohort of patients that we provide care for. It was a great way of improving communication and expectations for this cohort of patients.

CPD review project group update

The CPD review project group (CPD-RPG) formed to review and update the ANZCA and FPM CPD program to align with the Medical Board of Australia (MBA) revised CPD registration standard (effective 1 January 2023) and the Medical Council of New Zealand (MCNZ) recertification documents (effective 1 July 2022).

UPDATES TO THE ANZCA AND FPM CPD PROGRAM

Throughout 2022, the CPD-RPG and CPD committee have been reviewing and updating your CPD program to align with the revised regulatory requirements. Full details, including progress updates are available on the project's dedicated page on the college website.

The updated ANZCA and FPM CPD program will start on 1 January 2023. It will continue to be high-quality, enabling you to meet regulatory requirements. We are proud of the project's member-centered approach and are committed to minimising disruption to you while transitioning to the updated program. We anticipate this process will be seamless, automatic, and tailored to which triennium you are in.

This article supports our regular communication on the project's development and builds on the email sent to all CPD participants in May.

HAS ANYTHING CHANGED YET?

There are no changes to CPD requirements or submission dates – yet. We will share information with you as it becomes available, so please keep an eye on the project webpage and college publications.

There will also be individualised notifications in your CPD portfolio, which we ask that you regularly update to ensure you are ready for 2023.

CPD REVIEW PROJECT PROGRESS

The CPD-RPG is a fellow and CPD participant-led project. CPD-RPG members represent a variety of locations, scopes of practice and stages of fellowship.

In consultation with key stakeholders, the group have:

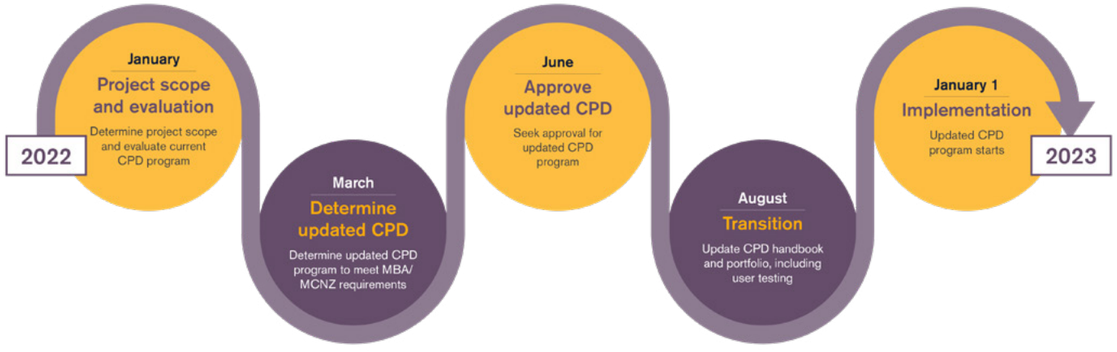
- Determined the project scope.
- Evaluated the current CPD program.
- Developed a framework for the updated CPD program.

Following approval of the updated CPD program, we will make updates to the CPD handbook and CPD portfolio. The portfolio will retain familiar features such as the dashboard and auto-population of activities, while also introducing key upgrades in response to participants' feedback.

HOW CAN I FIND OUT MORE?

All updates – including communications shared thus far and details of the updated CPD program will be shared on the project webpage. Please send any queries regarding the CPD review project to the CPD team and we will include these in an FAQ section on the project webpage.

We thank you for your patience as we review the CPD program to meet the revised regulatory requirements. The CPD team, project group and committee are here to support you during the transition and welcome your insights.



ARE YOU INTERESTED IN PROVIDING FEEDBACK ON THE PROJECT OR CPD PORTFOLIO?

We are looking for CPD participants to assist with CPD experience stories and user testing for the online CPD portfolio in August – September 2022. Please email cpd@anzca.edu.au to indicate your interest.

Please note the above information is correct at the time of publication. For updated information please see the project webpage – anzca.edu.au/education-training/anzca-and-fpm-cpd-program/cpd-review-project-group

CPD results

2019-2021 CPD TRIENNIUM

Congratulations to all 1113 participants in the 2019-2021 CPD triennium on achieving 100 per cent completion. This is an amazing achievement and shows the dedication you have to maintaining your professional development and recording it in your CPD portfolios.

With the previous triennium, 2018-2020, also achieving 100 per cent completion, this means just under 3000 fellows and CPD participants have maintained their CPD requirements during the COVID-19 pandemic.

Since the introduction of the current 2014 CPD program, we have been very proud of our end-of-triennium process results. Annually they have achieved between a 98-100 per cent completion rate. This is the second time in a row we have achieved 100 per cent completion.

The CPD Committee and team now move focus to supporting the 2020-2022 CPD triennium with the largest cohort of 3500+ participants. For more information, motivating stats and to hear from CPD Committee Chair, Dr Debra Devonshire please visit our website news item – anzca.edu.au/news.

2021 VERIFICATION (AUDIT)

The 2021 verification (audit) of CPD activities is complete with 100 per cent successful verification. We thank the 480 fellows and CPD participants selected for this year's verification for updating your CPD portfolios and demonstrating CPD compliance.

Our CPD program completes an annual audit to comply with the requirements of the Australia Medical Council (AMC) and MCNZ accreditation. A minimum of 7 per cent of all fellows and CPD participants are randomly selected through the online CPD portfolio system to verify their CPD activity records each year.

This is the first time the college has achieved 100 per cent successful verification. We have a proud record on accuracy and completion with our annual verification results between 98.3-99.5 per cent compliance over the past five years. Additionally, almost all of the very small percentage that could not be successfully verified in their year have since been supported and are now up to date and actively entering their CPD activities.

For full details please visit our website news item – https://www.anzca.edu.au/news.

Dr Debra Devonshire
CPD Committee Chair

My CPD experience

Dr Jacob Koshy FANZCA shares his experience with the ANZCA and FPM CPD program as Director of Anaesthetics at Alice Springs Hospital and member of the CPD review project group.

I was awarded my FANZCA in 2007, having progressed through the Special International Medical Graduates (SIMG) pathway. Preparing and passing the Part 2 (Final) fellowship examinations while working in a remote hospital was quite the challenge. I had to adapt to find resources and ways to keep abreast of clinical educational material.

I learnt to network with others in the same situation and learnt to ask for help. I found consultants in other bigger centres willing to sacrifice their time and share knowledge to help me prepare for the examination and life as a consultant in Australia.

The reason I start with this is to help people understand that meeting the requirements of the ANZCA and FPM Continuing Professional Development (CPD) program while living in a remote city can be challenging – but these challenges are not insurmountable as with preparing for examinations!

I have chosen to live and work in Alice Springs and have done so for 18 years. So how do I maintain my CPD requirements?

I have been active on our hospital committees and regular Mortality and Morbidity (M&M) meetings as well as teaching commitments which has helped with some CPD requirements.

I enjoy attending conferences and continuing medical education (CME) events and even though it would require travel and being away from home – it is a welcome break. That is, when we have adequate staffing to support this leave.

Then the unthinkable happened, the COVID-19 pandemic, and that threw up a significant challenge for all, let alone how to meet CPD requirements.

But in true testament to the resilience of the college, new ways were considered and even recognition of what departments were doing to plan and prepare for COVID-19 pandemic became something we could claim, listed on the COVID-19 – information for CPD participants' webpage.

The provision for some Emergency responses, with the new COVID-19 airway management, and others to be done online was fantastic and I think done very well.

Fulfilling the Practice evaluation mandatories (patient experience survey, multi-source feedback (MsF), peer review or clinical audit) is also a challenge. However, I have been fortunate enough to have great colleagues in our small department, who have been happy to help each other with the peer review and MsF.

Our recovery room nursing staff after being briefed on the patient experience survey, have been fantastic in helping us facilitate this process and helping us improve our clinical care. The clinical audits have been more demanding, but this has been achieved as well!

Working in a remote hospital can be challenging in many ways. It is also easy to feel isolated and develop a sense of disconnect with the college. I felt that this was not healthy and began to encourage other consultants in the department to actively participate in college activities.

Remote representation on the CPD review project group

When the applications for interest in joining the CPD review project group was put out on the website, I was keen to be part of it. Knowing the unique challenges of remote area work and the impact on CPD, I was keen to be able to provide a perspective in discussions that would ensure those challenges were also considered in decision making.

Since the group's creation in October 2021, my experience in the group has been incredible. I have felt welcomed and listened to. I have developed a huge appreciation for the excellent calibre of the administrative staff who work behind the scenes on this and other projects.

The future of our CPD is formed by strong foundations

I think we have an amazing CPD program thanks to the tireless work of those who have passionately spent time working on it. The support, the user-friendly dashboard of the online CPD portfolio all make for a very positive experience of trying to maintain our CPD requirements

The new CPD framework, as required by the Medical Board of Australia and Medical Council of New Zealand, will come into place in the near future. It comes with a unique set of challenges. But I have no doubt that with the amazing team working to develop it in the best interest of fellows, that just as we have done in the past, we will come out with system that will be agile, robust, and not burdensome.

Dr Jacob Koshy, FANZCA
Alice Springs Hospital

- Full details on the CPD review project group can be found on our website.
- The CPD handbook contains helpful details on requirements, activities, CPD values and supporting appendices such as forms and guidelines. Including details on the articles mentioned activities:
  - Practice evaluation mandatories.
  - Practice evaluation "Mortality and Morbidity meetings" activity.
  - Knowledge and Skills "Teaching" activity.
  - Knowledge and Skills "Committee meetings" activity.
  - Emergency Response "COVID-19 airway management" activity.
- The COVID-19 – information for CPD participants' webpage holds helpful information about CPD activities that can be considered in response to the persistent pandemic, including COVID-19 simulations and team training scenarios.
- There are many ways to get involved at the college, including applying for a committee role or joining a specialist interest group, full details available on contributing to your specialty webpage.

Got a CPD experience you'd like to share?

The college is actively seeking fellows and CPD participants to share their experiences with the ANZCA and FPM CPD program by answering the question "How do you meet your CPD requirements?". Please get in touch with our helpful CPD team at cpd@anzca.edu.au with your interest.

Global Development Committee farewells Dr Michael Cooper

Dr Michael Cooper during one of his early visits to PNG.

AFTER 10 YEARS, Dr Michael Cooper has chaired his final meeting of the college's Global Development Committee. Dr Cooper is a senior anaesthetist at The Children's Hospital in Westmead and St George Hospital in Sydney and adjunct professor of anaesthesiology at the School of Medicine and Health Sciences, University of Papua New Guinea.

After starting his medical career at St Vincent's Hospital in Sydney, first as a medical student and later a resident and then registrar, Dr Cooper was attracted to paediatric anaesthesia after a rotation at the Royal Alexandra Hospital for Children at Camperdown (now The Children's Hospital at Westmead). Here he met one of his mentors and lifelong friends, Associate Professor John Overton who was director of anaesthesia at the time. Dr Cooper subsequently accepted a position at the Royal Alexandra Hospital following his training.

He headed overseas in 1990 and spent six months at the Boston Children's Hospital, where the world's first paediatric pain unit was established in 1985. He returned to Australia armed with new skills and techniques in paediatric pain management and a desire to develop a similar unit at the Royal Alexandra Hospital.

It was during his time as a student in 1981 that he first visited Papua New Guinea (PNG) for a final year elective and administered his first anaesthetic in the Southern Highlands in a small provincial hospital. Twenty years later he made his first trip as a specialist to PNG when the opportunity arose to accompany a paediatric surgical team. He has visited PNG most years since (with recent exceptions due to COVID-19) under the auspices of various Department of Foreign Affairs and Trade programs through the Royal Australasian College of Surgeons.

The Australian Society of Anaesthetists (ASA) had a long and well established Overseas Development and Education Committee which provided support to many Pacific nations including Fiji and Micronesia. However, there was a gap in support for the small number of anaesthetists in PNG. With some of the worst health statistics in the region, Dr Cooper recognised the opportunity to improve safe anaesthesia in the country. With strong support from anaesthetists in PNG and ANZCA, several teaching visits were organised in 2005 and 2006.

Professor Garry Phillips, ANZCA president from 1996-98, was a visiting Professor of Anaesthesia at the University of Papua New Guinea's School of Medicine and Health Sciences from 1997 until 2004 and, along with Dr Cooper and other anaesthetists from Australia and PNG, established a PNG anaesthesia working party. Over the next few years the college supported continued teaching visits and other initiatives such as scholarships.

In 2010 this working group was formalised as the ANZCA Overseas Aid Committee with Dr Wayne Morriss as chair and a focus on supporting anaesthesia in PNG, to complement the work of the ASA's Overseas Development and Education Committee in the Pacific. Dr Cooper took over as chair of the committee in 2012.

Under his stewardship, the committee has grown and, in collaboration with other colleges and societies, has expanded both its reach within the Asia Pacific and its range of non-clinical support programs and initiatives. In 2020 the committee changed its name to the Global Development Committee to better reflect the role and purpose of its work.

> "Dr Cooper has made an enormous contribution to the Global Development Committee and improving the safety of anaesthesia and surgery in PNG and beyond."

Clockwise from top left: Past ANZCA President Associate Professor David A Scott with PNG anaesthetist Dr Pauline Wake and Dr Cooper at a meeting in Port Moresby in 2017; Dr Cooper being interviewed by ABC journalist Eric Tlozek in Port Moresby in 2017; Dr Cooper taking time out with PNG anaesthetists; Dr Cooper in theatre in Port Moresby Hospital.

The committee now supports a range of programs in countries including Mongolia, Indonesia and Timor-Leste however its focus remains on PNG. Dr Cooper was instrumental in the ANZCA International Scholarship which supports a consultant anaesthetist or pain medicine specialist from a low- and middle-income country to work in a hospital in Australia or New Zealand for up to a year. Designed to increase the recipient's capacity to advance anaesthesia and pain medicine for the benefit of their community, ANZCA has offered the scholarship since 2005. Seven scholarships have been awarded since then to recipients from countries including PNG, Fiji, Myanmar, Solomon Islands and Kenya. The most recent recipient was Dr Pauline Wake, now a senior lecturer at the School of Medicine and Health Sciences, University of Papua New Guinea.

Since its inception, the Global Development Committee has been a strong supporter of medical students and anaesthesia trainees in PNG. Prior to COVID-19, two committee members attended the annual Masters of Medicine (Anaesthesiology) and Diploma of Anaesthesiology examinations in person to assist. In recent years, the exams have been run with external examiners taking part remotely in the assessment via Zoom. In 2021, a record number of seven doctors sat the Masters of Medicine (Anaesthesiology) and Diploma of Anaesthesiology exams and all passed – a fantastic achievement for both them and their communities.

Dr Cooper also has a long involvement with the World Federation of Societies of Anaesthesiology (WFSA) and is immediate past chair of the WFSA's Paediatric Anaesthesia Committee. He also has a keen interest in medical history and is history editor of the journal *Anaesthesia and Intensive Care*. In 2018 Michael was awarded a Member of the Order of Australia for significant service to medicine in the field of anaesthesia as a clinician, teacher, mentor and historian.

Dr Cooper has made an enormous contribution to the Global Development Committee and improving the safety of anaesthesia and surgery in PNG and beyond. We thank him for his 12 years of dedicated work as chair and member of the committee and know he will continue to play an important role in many of the committee's programs, particularly educational support for our colleagues in PNG.

Dr Yasmin Endlich, FANZCA
Chair, Global Development Committee

An appreciation from PNG anaesthetists

Dr Michael Cooper with PNG anaesthetists in Port Moresby

DR MICHAEL COOPER has had, and continues to have, an illustrious and colourful relationship with Papua New Guinea (PNG). He first visited the country in the 1980s but has since continued visiting many times, travelling to both the coastal and highlands regional hospitals.

On completion of his training as a specialist anaesthetist he returned to PNG to assist in the delivery of specialist paediatric anaesthesia services as well as the training of anaesthetists. One or two registrars would accompany him on his paediatric surgery visits each time he came with Dr Albert Shun.

Most of the specialists who have passed through their anaesthesia training at the University of Papua New Guinea in the past two decades have felt his influence in their training. Many anaesthesia technical and scientific officers have also received teaching from him during his trips as part of the paediatric surgery team, or as lecturer to the medical school. These are the ones who undertake most of the anaesthetic work in PNG given that there's less than 25 actively practising specialist anaesthetists in the whole country.

Over the past decade as chair of the ANZCA Global Development Committee, and also as Adjunct Professor of Anaesthesia at the University of PNG School of Medicine and Health Sciences, Dr Cooper has held many teaching sessions, delivered many lectures and workshops, attended the annual Society of Anaesthetists of Papua New Guinea (SAPNG) meetings, and examined many registrars who have gone on to graduate as specialists and are working in the country.

Another exciting project the SAPNG has worked on with Dr Cooper and the college has been the distribution of more than 1100 Lifebox pulse oximeters throughout the country. In 2012 we started with 40 oximeters, placing one or two in every provincial hospital operating theatre. In the following years, we placed an oximeter in every recovery room and subsequently went on to place oximeters in the operating rooms of many church-run hospitals who serve the majority of the rural population in PNG. We have also distributed some to intensive care units, high dependency units, paediatric wards, special care nurseries and even some smaller health centres.

In 2020-2021 during the COVID-19 pandemic, Dr Cooper was able to organise another 150 oximeters from Lifebox and we distributed these to provincial centres around the country who were struggling with managing rising cases. Fifty of these oximeters were officially handed over to the National Health Department on behalf of ANZCA in November 2021, which were then paired to each oxygen concentrator that was being send out to COVID-19 affected centres around the country.

One personal recollection I have is being picked up by Dr Cooper from Sydney Airport in 2012 and staying at his house where I noticed 20 cartons filled with books and other teaching materials for each of the 20 provincial hospitals in PNG. He brought these up to Port Moresby during the annual SAPNG conference in September that year and distributed them to the representatives of each provincial hospital.

His influence in training and in paediatric anaesthesia has played a big role in the development of the specialty in PNG and also in the recent development of the post graduate higher diploma course in paediatric anaesthesia at the University of PNG.

The SAPNG thanks Dr Cooper sincerely for so much work done, not only to advance anaesthesia specialty training in PNG, but especially more so for the hundreds of kids who have benefited from specialist paediatric surgery visits over the last two decades, which he has performed with our good friend Dr Albert Shun.

We wish him all the best in his next endeavours.

Thank you Michael.

Dr Arvin Karu
President, Society of Anaesthetists of PNG
Division of Anaesthesia and Intensive Care, Port Moresby General Hospital

Supporting ANZCA Research

Over the past few years, the ANZCA Library has developed a suite of library guides to better support ANZCA research-related activities.

RESEARCH SUPPORT HUB

Not sure what you're looking for or where it's located? The hub is designed to bring together the various services, resources and guides provided by the college and ANZCA library to support research-related activities. Each service, resource or guide is briefly summarised, with supporting links to get you quickly to where you need to be.

The hub is linked from a number of places including the ANZCA Library home page and the Research home page on the college website.

RESEARCH SUPPORT ESSENTIALS

Aimed at the novice researcher, the Research Support Essentials guide brings together core research-related resources. This includes key articles, books and e-books, online presentations, and websites. It's a good place to learn more about the basics of research gathering, prepping for a paper, or making a presentation.

There is also a section highlighting upcoming college-related and research-focused workshops, events and webinars – and often includes links to recently recorded webinars.

RESEARCH SUPPORT TOOLKIT

This in-depth toolkit brings together information resources related to the area of research, the research life-cycle and the college resources available to support ANZCA researchers. It offers a primer for emerging investigators and research co-ordinators who would like to know more and support materials for both new and established researchers.

There are extensive links to resources supporting all phases of the research life cycle, including getting started (for example, grants, new researcher support, budgeting), through to conducting your research (for example, existing evidence, gather new evidence, evidence collation) and publishing your paper (for example, writing a paper, where to publish, metrics).

RESEARCH CONSULTATION SERVICE

The Research Consultation Service provides research support to fellows, trainees, college staff and other key college stakeholders through the expertise and experience of a research librarian.

The college's research librarian is available to undertake literature searches, respond to queries related to the conduct of research, and teach academic/information literacy skills. The reference librarian assists with evidence-based decision-making within ANZCA, collaborating on the development of college and faculty curriculum and professional documents.

AIRR

The ANZCA Institutional Research Repository (AIRR) collects, preserves and promotes the significant amount of important research published by college and faculty fellows and trainees.

Researchers/authors are able to register and then self-submit articles or create a profile. AIRR also contains every available PDF copy of the *ANZCA Bulletin*, as well previous editions of *Australasian Anaesthesia* (also known as the "Blue Book") and *Acute Pain Management: Scientific Evidence* (APMSE).

PROFESSIONAL PRACTICE RESEARCH (PPR)

This recently launched guide was designed as a means of promoting and providing curated access to relevant resources related to research in the professional practice domains – communicator, collaborator, leader and manager, scholar, health advocate and professional – in anaesthesia, perioperative medicine and pain medicine.

It supports the specialised qualitative and mixed-methods research being undertaken by fellows and trainees.

ROLES IN PRACTICE

A selection of curated resources to support the roles in practice topic areas for trainees: medical expert, communicator, collaborator, leader and manager, health advocate, scholar and professional.

It includes the recently revamped Communicator Role guide, and the always popular Scholar Role resources.

LITERATURE SEARCHING

Support is available for users who want to undertake their own literature searches, with a comprehensive guide based on the Medline database training sessions offered at ASMs, and with links to the literature search learning module in Networks.

DATABASES AND COLLECTIONS

ANZCA library provides access to a range of specialised medical and education databases and collections, including Ovid Medline, PubMed (with full-text access), Trip Pro and Therapeutic Guidelines.

COVIDENCE

Covidence is a web-based tool that improves healthcare evidence synthesis by improving the efficiency and experience of creating and maintaining systematic reviews through automation, collaboration and peer review.

REFERENCING

Learn more about the how to assemble and format citations appropriate for your needs through the Referencing library guide. Access the ANZCA style guide, download the ANZCA EndNote connection style and reference types, and learn more about the freely available citation managers.

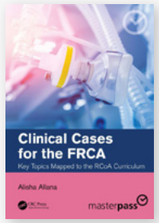
CONTACT THE LIBRARY: +61 3 9093 4967 library@anzca.edu.au anzca.edu.au/resources/library

New books

NEW EXAM BOOKS

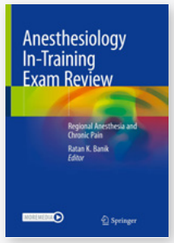
A number of new primary and exam prep titles are now available online:

https://libguides.anzca.edu.au/training-hub



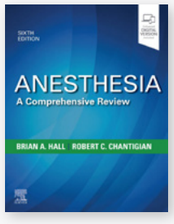
Clinical cases for the FRCA: key topics mapped to the RCoA curriculum

Allana A. Boca Raton, FL : CRC Press, 2021.



Anesthesiology in-training exam review: regional anesthesia and chronic pain

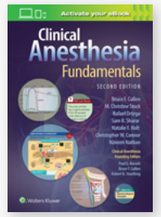
Banik RK. Cham, Switzerland : Springer, 2022.



Anesthesia: a comprehensive review, 6e

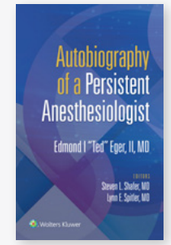
Hall BA, Chantigian RC, Mayo Foundation for Medical Education. Elsevier, 2019.

NEW EBOOKS



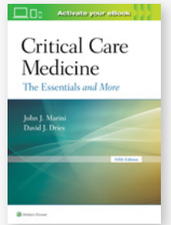
Clinical anesthesia fundamentals, 2e

Cullen BF [ed.]. Philadelphia, PA: Wolters Kluwer, 2022.



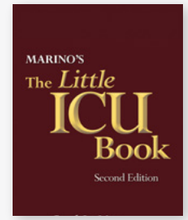
Autobiography of a persistent anesthesiologist

Eger EI. Philadelphia: Wolters Kluwer, 2022.



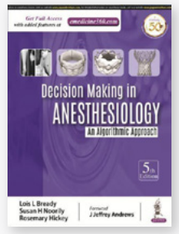
Critical care medicine: the essentials and more, 5e

Marini JJ, Dries DJ. Philadelphia: Wolters Kluwer, 2019.



Marino's the little ICU book, 2e

Marino PL, Galvagno SM Jr. Philadelphia: Wolters Kluwer, 2017.



Decision making in anesthesiology: an algorithmic approach, 5e

Bready LL, Noorily SH, Hickey R [eds]. Delhi: Jaypee Brothers Medical, 2020.

The Massachusetts General Hospital handbook of pain management, 4e

Brenner G, Rathmell JP [eds]. Philadelphia: Wolters Kluwer, 2021.

Following high demand, the library has recently purchased additional print copies for the majority of the primary exam texts, including *West's respiratory physiology: the essentials, 11e* and *The physics, clinical measurement, and equipment of anaesthetic practice for the FRCA, 2e*.

Books can be borrowed via the *ANZCA Library catalogue*: http://www.anzca.edu.au/resources/library/borrowing

What's happening in the foundation

PADDI trial wins prestigious statistics award

The foundation warmly congratulates the Perioperative administration of dexamethasone and infection (PADDI) trial team, who received the 2022 Australian Clinical Trials Alliance (ACTA) Excellence in Trial Statistics Award on 20 May.

PADDI was endorsed and administered through the ANZCA Clinical Trials Network, and led by Principal Investigator Professor Tomas Corcoran, Director of Research, Department of Anaesthesia and Pain Medicine, Royal Perth Hospital.

The assessment panel said PADDI demonstrated exemplary statistical trial design, planning, analysis, reporting and interpretation. Professor Andrew Forbes from Monash University's School of Public Health and Preventive Medicine was the lead trial statistician. For more information about the trial visit the ANZCA website.

University pathways for emerging researchers webinar

More than 100 fellows and trainees registered for the second "Foundation Friends" webinar on 14 April to hear how the foundation is supporting emerging researchers in achieving academic research qualifications.

Professor Kirsty Forrest, Dean of the School of Medicine at Bond University, Gold Coast, Queensland, spoke about the important role of academic education in research careers. Professor David Story, Foundation Professor of Anaesthesia and Head of the Department of Critical Care at the University of Melbourne, discussed ANZCA Foundation support for emerging researchers through grants and the clinical trials network, and the value of conducting research in a university department.

Associate Professor Jai Darvall

Associate Professor Jai Darvall shared his personal journey from novice to accomplished emerging investigator, why a PhD was important for him, and help he received through foundation grant including a donor scholarship.

The foundation thanks our fantastic speakers and all those who kindly registered for and attended. For all those who could not attend in real time, a video recording is available via the ANZCA Library's online Research Hub.

Research grants webinar

The foundation worked with the ANZCA Clinical Trials Network in February to deliver a webinar on our research grants program. Comprehensive content was delivered by ANZCA Research Committee Chair, Professor David A Scott.

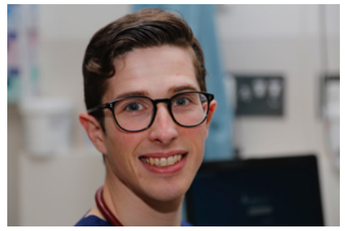
Participants received information designed to improve applicants chances of success. Content covered application and grant numbers, assessment process, eligibility criteria, research questions and hypotheses, potential benefits, priority areas, feasibility, study design, pilot studies, application writing and presentation skills, ethics, mentoring, and available ANZCA resources.

The webinar video is also available in the ANZCA Library online Research Hub.

Foundation grant study accepted by The Lancet

The foundation was recently notified by one of our fellows that the IDOCS study on iron deficiency and outcomes following elective cardiac surgery (ANZCA Research Foundation Grant 18/034) has been accepted for publication by The Lancet Haematology (2022 Impact Factor 19). Principal investigator Associate Professor Lachlan Miles wrote:

"This study would not have been delivered if it were not for the ANZCA Research Committee and the foundation taking an enormous punt on a very junior and untested principal investigator in 2017. The study was funded from a foundation project grant, with a single top up from the ANZCA Emerging Researcher Scholarship (also funded through the foundation with the assistance of that great philanthropist, Dr Peter Lowe).



Associate Professor Lachlan Miles

Of course, the foundation is directly acknowledged in the manuscript. I am sure that the foundation by now is very used to work they have funded being published in high impact journals. However, I am certainly not used to it, and so I wished to share this good news, and say 'thank you' for the role you have played in my work to date, and hopefully long into the future." The foundation thanks our wonderful donors who make such outcomes possible!

Patrons and donors

It is also timely for the foundation to thank our generous donors who make the support we provide possible – particularly our Foundation Patrons, who pledge significant annual giving and provide a vital "financial foundation for the foundation". If you would like to consider being a patron, please contact me or go to our ANZCA website pages to join this prestigious program.

Rob Packer
General Manager, The ANZCA Foundation

CONTACT US

To donate search "GiftOptions – ANZCA" in your browser. For foundation queries, contact:

- **Rob Packer**
  General Manager
  +61 3 (0)409 481 295,
  rpacker@anzca.edu.au
- **Leah Wolf**
  Fundraising Administration Officer,
  lwolf@anzca.edu.au

For research grants program queries:

- **Susan Collins**
  Research and Administration Co-ordinator,
  scollins@anzca.edu.au

Tranexamic acid stems bleeding during non-cardiac surgery

POISE-3 trial tranexamic arm results

THE POISE-3 TRIAL was a two-by-two factorial trial led by the Population Health Research Institute in Canada to evaluate the safety of tranexamic acid in terms of bleeding complications after non-cardiac surgery without increasing the risk of stroke and other vascular events. The trial ran worldwide across 149 sites in 24 countries. Australian and New Zealand sites recruited 743 patients across 20 sites under the leadership of Dr Thomas Painter, Dr Elizabeth Maxwell and Professor Kate Leslie AO, and funding from the National Health and Medical Research Council (NHMRC). Despite the pandemic, the trial ran ahead of schedule with the recruitment of nearly 10,000 patients completed in two-and-a-half years.

Perioperative bleeding is a common complication in patients undergoing noncardiac surgery. Tranexamic acid is an antifibrinolytic drug that is commonly used by anaesthetists in cardiac surgery, however, in noncardiac surgery, the safety profile and efficacy of tranexamic acid has not been established. The tranexamic arm (TxA) of the POISE-3 trial set to definitively answer whether TxA reduced the occurrence of life-threatening, major, and critical organ bleeding and whether TxA was noninferior for the occurrence of major vascular complications within 30 days compared to placebo.

POISE-3 was designed as a multi-centre, investigator-initiated blinded, randomised, partial two-by-two factorial trial design in which patients 45 years and older planning to undergo noncardiac surgery and were at risk for perioperative bleeding complications and vascular events were randomly assigned to receive TxA or placebo. For the blood pressure arm, patients who were on antihypertensive medications were randomised to hypotension versus hypertension avoidance strategy.

The POISE-3 study randomised 9535 patients having noncardiac surgery to tranexamic acid (TXA) or matched placebo. The incidence of composite bleeding outcome was significantly lower with TXA (9.1%) than with placebo (11.7%) (hazard ratio, 0.76; 95% CI, 0.67 to 0.87; absolute difference, −2.6 percentage points). The incidence of the composite safety outcome (myocardial injury, stroke, arterial thrombosis, VTE) was 14.2% in the TXA group and 13.9% in the placebo group (hazard ratio, 1.02; 95% CI, 0.92 to 1.14; absolute difference, 0.3 percentage points).

In patients having noncardiac surgery, pre-operative tranexamic acid reduced bleeding complications however non-inferiority for vascular complications within 30 days of surgery was not established. As the absolute difference in the safety outcome was small, wider use of TXA in noncardiac surgery seems justified. As TxA is inexpensive these results will be rapidly translated into practice in Australia.

The results have been published in the *New England Journal of Medicine* building on the outstanding track record of CTN to deliver large multicentre trials and to improve the evidence-base and patient safety in pain, anaesthesia and perioperative medicine. Dr Painter presented the results recently in front of a large virtual audience at the 2022 ANZCA ASM in the late breaking trials session. We thank all sites and the project team for their dedication to the trial.

For more information about the POISE-3 trial:

https://www.nejm.org/doi/full/10.1056/NEJMoa2201171
https://www.anzca.edu.au/profiles/ctn-trials/published/poise3

Dr Tom Painter
National leader for Australia and New Zealand, POISE-3 Trial
Specialist anaesthetists, Royal Adelaide Hospital

Karen Goulding
ANZCA Clinical Trials Network Manager

ANZCA Primary Fellowship Examination

2022.1 Exam

One hundred and forty-five candidates successfully completed the primary fellowship examination:

AUSTRALIA

Australian Capital Territory

Nicholas John Goulding

New South Wales

Falko Frederick Adermann
Mariam Habib Awad
Myles David Barnett
Timothy Jared Basevi
Hannah Eilish Braithwaite
Andrew Robert O'Halloran Brazier
Benjamin Kum-Fung Chau
Lachlan James Cormick
Mitchell Campbell Deck
Brigid Therese Doolan
Hailey Frances Drinkwater
Timothy Jack Peter Durack
Nicola Alana Fraser
Abishana Gnaneswaran
Shobha Rani Halavudara Gururaja Rao
Jaffar Hosain
Gregory Kranias
Jason Chin Yin Kwok
Karmen Elizabeth Jacqueline Magi
Michael Christopher Millett
Johnson Chi Wa Ng
Jason Sing Chi Ngai
Michael O'donnell
Adam Patrick Pasfield
Morgan Olivia Pengelly
Eric Donald Quin
Ravitej Raghothama
Sarah Louise Ritchie
David Peter Rohl
Stephen James Sanchez
Adam Skelton
Bethany Kathleen Smith
Patrick Michael Murray Smith
Jason Yuk Hei Tang
Raymond Tann
Deniz Tat
Ramez Zaklama
Joseph Hodgson
Brigitte Claire Holt
Joshua Wen-Jun Lin
Sukhi Manjunatha Hedge

Northern Territory

Henry Bear
Sihui Liu

Queensland

Anirudh Bhardwaj
Shreyas Rao Boppana
James Alexander Lachlan Boyle
Matthew Joseph Ciantar
Kyle Mathew Dailey
Gihan Climaque Hapuarachchi
Dr Dat Khuong Huynh
Bonny Clare Jones
Jimin Kang
Alexandra Peta Grace Kanowski
Daniel Kwanwoo Kim
Geraldine Wen Bin Kong
Dickson Bacon Chi Woo Lee
Angus Loraine
Paras Lovel
Alexandra Rose Lyons
Rebecca Anne Martin
Elizabeth Alice Parkinson
Hamish Raniga
Gowri Manohari Ravichandran
Fiona Ruth Ryan
Peter Richard Smedley
Dilip Raj Sunder Raj
Susanna Angela Van Haeringen
Jessie Ruijun Wang
Lachlan Horton Young
Joanna Hui Li Yu
Aisha Safia Bouhafs
Srey Neth Loch
Greer Patrice Megaloconomos
Timothy Douglas Gilmour
Alexander James Francis Smithers

South Australia

Ai Duyen Nguyen
Hamza Baig
Joseph Benedict De Zylva
Annie Lin
James Manil Joseph Navaratne
Mina Selim
Evelyn Joy Timpani

Tasmania

Alexander James Head Lewis
Vera-Lisa Loubser
Sandeepal Singh Sidhu

Victoria

Ryan David Francis Adams
Daniel Alexander Axelsson
Stephanie Lily Barreto
Meghan Kate Bowtell
Hamish Lewis Brown
Millicent Kuczynska Burggraf
Olivia Meredith Coleman
Rudi Daniel Falovic
Michael Handscombe
David Edward Heelan
Bridget Lesley King
Nicholas William Blake Lower
Andy Ding Li Ngoi
Jennifer Louise Norman
Zachary Phillip O'Brien
Marie Domenique Palumbo
Jennifer Kate Preddy
Shalley Anna Robins
Stephen James Edward Sharp
Catherine Smale
George Li Yi
Bryan Sing Hung Yip
Annetta Yang Yang Zheng
James Francis Zwirs
Mark Yan-Nan Huang
Brooke Michelle Ward
Thomas Zac Curtis

Western Australia

Nathan David Blakely
Cayley Jayne Bush
Alexandra Lauren Carle
Elizabeth May Carr
Julian Shao Jian Chung
Rowan Derrick Ellis
Alexander Athelstan Gadd
Julie Isbill
Amy Louise Lumb
Timothy James Marmion
Sarah Catherine O'Brien
Declan Alexander Thomas Scott

NEW ZEALAND

Jayden Charles Ball
Makere Jane Baele
Xavier Benito Bergantino-Mitu
Ching-Wen Chou
Martin James Churcher
Sean Cox
Ben Drinkwater
Nathan Luey
Brittany Mary MacDonald
Hannah Teresa Middleton
Monica Eileen Mullally
Richard Luo Oliver
Matthew John Payne
Robyn Merle Scott
Sami Harith Swadi
Peninatautele Maria Taimalelagi
Kristen Anne Wadwell
Henry James Watson
Sarah Wongseelashote
Louis Yin

RENTON PRIZE

The Court of Examiners recommended that the Renton Prize at this sitting of the primary examination be awarded to:

Alexandra Lauren Carle, Western Australia

MERIT CERTIFICATE

The Court of Examiners recommended that a merit certificate at this sitting of the primary examination be awarded to:

Declan Alexander Thomas Scott, Western Australia

ANZCA Final Fellowship Examination

2022.1 Exam

One hundred and forty-five candidates successfully completed the final fellowship examination:

AUSTRALIA

Australian Capital Territory

Lucy Sarah Davidson
Mark Christopher Giddings
Alex Wang

New South Wales

Terrence Desmond Alfred
Lukman James Anderson
Lauren Appleton
Jessica Lee Barry
Kenneth Chiu Vin Cheung
Daniel Christopher Chilton
Simon Cole
Michael Peter Connolly
Sophie May Connolly
Daniel Ferris
Stephany Marie Game
Emma Catherine Harknett
Cheng Fai Hui
Shaun Michael Jones
Patrick Barry Kroek
Varahini Kumar
Deahnne Christine Levas
Christopher Sam Long
Christine Huanyi Ma
Belinda Jayne Mahoney
Timothy James Marshall
Samuel James O'Neill
Amit Mohindar Pancholi
Malik Salgado
Keshan Savinda Selvarajah
Jonathan Michael Tobin
Michael Sebastian Wesley Truelove
Andrew James Forte Turner
Victor Xin Yun Chen
Yuxuan Chew
Ellen Kathryn Coonan
Ryan James Devlin
Ashwini Dhanapathy
Elizabeth Ann Forrest
James Edward Nevin Gardiner
John Alan Ham
Esmond Qing Hii
Samantha Howard
Luke Yao-I Huang
Grace Elizabeth Kirkby-Strachan
Chia Yuan Lee
Thomas Robert McCall
Eavan Margaret O'Brien
Laura Giovanna Panizza
Thomas James Pearson
Michael Stuart Quinn
Andrea Senesi
Nicholas John Trott
William John Turk
Kathleen Marianne Turner
Sophie Louise Turner
David Graham Walker
Jing Yuan Jessica Wu

Queensland

Arielle Christa Beech
Robert Henry Burnett
Samuel Joseph Butler
Benjamin Lewis Cahill
Julia Lee Carter

South Australia

Munro Alexander Brett-Robertson
Thomas Isaac Druery
Christopher James Colin Edwards
Laura Fisher
Rebecca Elizabeth Madigan

Tasmania

Nicola Alison Fracalossi
Sophie Maslen
Stuart Maurice Paterson
David Edward Somerville-Brown

Victoria

Diana Abu-Ssaydeh
Yi-Wei Baey
Craig Robert Beaman
Bridget Frances Bishop
Alexander Gilbert Jacques Cochrane Davis
Alexander Brown Courtney
Patrick Anthony Dhar
Peter Robert Stanley Forrest
Patrick Stewart Galloway
Luke Bryden Garbett
Lisa Gong Gu
Nathaniel John Hiscock
Nicole Hobday
Emily Louise Jenkins
Teck Hock Khoo
Eugene Constatine Lai
Adam Brett Levin
Max Elliott McCartney
James Meneguzzi
Alexander John Morris
Li Yong Ng
Benjamin Charles O'Sullivan
James Henry Phillips
Lily Belle Poulier
Adam Gerald Scorer
Dylan Siejka
Lyndsay Erin Thompson
Anurag Vijay
Rukman Vijayakumar
David Wang
James Duncan Warner
Martin Harry Warren
Lucas Wheat
Yuan Yi

Western Australia

Lip Yong Choo
Thomas David Cordery
Clinton Dillon Ellis
Hamish William Johnston
Claudia Marcelle Lagrange
Jolene Shu Ning Lim
Ng May Mun
Falk Reinholz
James Alexander Richardson
Michael James Edward Robbins
Declan Charles Jolley Sharp
Elliot Karl Smith
Katherine Pixley Smith
Eileen Linlin Zhang

NEW ZEALAND

Thomas Patrick Adamson
Wee Choen Ang
Alec Marshall Beresford
Simon Ian Brown
Crystal Mei Gan Chandler
Paul Patrick Drury
Midori Fujino
Aisling Marie Gormley
Lee Sean Gribbon
Carl Gordon Hume
Rory Alexander Jago
Alice Mary Jones
William Zhang Weiling Law
Tony Joo Hyeon Lee
Harriet Elizabeth Pilkington Miller
Thomas Kenneth Gordon Milne
Kamil Patel
Kathryne Balcom Roper
Dineth Nimantha Sumathipala
Gregory Phillip Thomas
Robert William Milnes Walker
Abigail Frances Weston
Adele Rachael Whiteman

SIMG EXAMINATION

Four candidates successfully completed the specialist international medical graduate examination:

Babak Gharaei, Vic
Amritha Menon, NSW
Naoko Nakaigawa, WA
Victor Voski, WA

CECIL GRAY PRIZE

No candidates were awarded the Cecil Gray Prize for the 2022.1 final examination.

MERIT CERTIFICATE

Merit certificates were awarded to:

Peter Robert Stanley Forrest, Vic
Nathaniel John Hiscock, Vic
Rebecca Elizabeth Madigan, SA

ANZCA
FPM

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Keep your details up to date on the MyANZCA portal. We use the information on your MyANZCA profile for all of our official communications, including:

Exam updates · Events and courses · Committee vacancies
Safety alerts · Hospital rotations · Research opportunities

So please take a few minutes to check your personal details. It's easy to do, and ensures you won't miss out on important information.

1. Log into anzca.edu.au/portal
2. Click "Update my contact details"
3. Ensure your details are up-to-date and click "save".

If you have multiple addresses you can select a preferred mailing address. You may also choose to let us know if you identify as Aboriginal Australian, Torres Strait Islander, Māori or Pacific Islander; and alert us to any dietary requirements.

If you're worried that you're not receiving our emails, please check your junk and spam filters and, if necessary, add @anzca.edu.au or @anzca.org.nz to your address book.

And don't forget to follow us on your favourite social media channels for all the latest news, events, and insights into college life.

New faces and issues for ANZCA in New Zealand

From left: Dr Geoff Laney, Dr Sarah Nicolson, Dr Vanessa Beavis, Dr Tim Starkie, Dr Graham Roper, Dr Jen Taylor, Dr Ralph Fuchs, Dr Tom Fernandez, Dr Rachel Dempsey, Dr Leinani Aiono-Le Tagaloa, Dr Lisa Horrell, Dr Lisa Barneto, Dr Brendan Little, Dr Amanda Gimblett. Missing from the photo: Dr Sally Ure and Dr Jo Coates.

The 2022-2024 ANZCA New Zealand National Committee (NZNC) met in Wellington on 1 July, the same day as the extensive health reforms were ushered in for Aotearoa New Zealand.

The combined meeting with the New Zealand Society of Anaesthetists heard from the chief executive of the Health and Quality Safety Commission, Dr Janice Wilson, who highlighted the huge job ahead with the health reforms. She said patient safety is a priority and anaesthetists have led the way on this internationally and in Aotearoa. Dr Wilson commended the doctors for their work.

The combined meeting also heard about concerns with the new degree-based assistant to the anaesthetist course which replaces the apprenticeship and one year program. A shortage of anaesthetic technicians in New Zealand is already a workforce issue.

The government drug-buying agency Pharmac had a team of three to talk to the combined meeting about the ongoing work to take over the purchase of all medical devices for the country. In the question and answer session following the presentation the three representatives were grilled on how nimble Pharmac can be in upgrading and changing when new devices and upgrades of machines are needed.

In the afternoon, the new NZNC met, with Dr Graham Roper taking over as chair and Dr Sarah Nicolson as deputy. The full list of the new committee and positions can be found on the ANZCA website.

South Australia and Northern Territory

SA ADVANCED AIRWAY MEETING

The SA ACE Advanced Airway Meeting was held at the Lion Hotel, North Adelaide on 6 April. Dr Yasmin Endlich presented on advanced airway techniques and delegates then had the opportunity to participate hands on in demonstration stations set up for VAFI and ATI, LMA to ETT exchange and Nasendoscopy .

The CME Committee would like to thank facilitators Dr Yasmin Endlich, Dr Giresh Chandran, Dr Joshua Lun, Dr Alicia Paterson and Dr Sophie Bradshaw for their efforts in putting together such a successful meeting.

SA ACE meeting delegates practicing advanced airway techniques.

Dr Roger Capps and Dr Yasmin Endlich.

Dr Munro Brett-Robertson, Dr Joshua Lun, Dr Yasmin Endlich, Dr Alicia Paterson, Dr Sophie Bradshaw and Dr Giresh Chandran.

Australian Capital Territory

2022 ART OF ANAESTHESIA "TOGETHER AGAIN"

On behalf of the ACT Regional Committees of ANZCA and the ASA, we warmly invite you to the Art of Anaesthesia meeting to be held in beautiful Canberra on Saturday 8 and Sunday 9 October 2022.

The organising team is very excited to host this face-to-face meeting after a two-year hiatus. This year the meeting will be held at Hotel Realm, a premier facility in the heart of Canberra that's in walking distance to the National Gallery of Australia, the National Portrait Gallery, Questacon, the National Library and the Kingston Foreshore.

The program is packed with outstanding speakers from across Australia, as well as several local experts and thought leaders. We are joined by Professor Bernhard Riedel from the Peter McCallum Cancer Centre, Professor Robert Sanders from the University of Sydney and Professor Imogen Mitchell from ANU. Professor Riedel will open the meeting with an important update in onco-anaesthesia, while Professor Sanders will explore anaesthesia and consciousness, followed by an update on postoperative delirium. Professor Mitchell will provide her insights into death and dying in critical care. We are also thrilled to host multiple interstate speakers, including Associate Professor Stefan Dieleman, Dr Jo Irons, Associate Professor Forbes McGain, Dr Jessie Ly, Associate Professor Adam Hastings and Dr Dani Goh, as well as a range of local speakers.

The program is intentionally broad and aims to provoke thought and discussion, with sessions on perioperative medicine and outcomes, neuroanaesthesia and neuroscience, environmental issues, health economics and gender surgery. The academic program on the Saturday will finish by 4pm to allow delegates time for wine, nibbles and a chat on the shores of Lake Burley Griffin.

On Sunday 9 October the program will feature several hands-on workshops, including Anaphylaxis Management and Major Haemorrhage workshops, both of which fulfil the Emergency Response Activity CPD requirements for ANZCA, as well as a practical focused Transthoracic Echocardiogram (TTE) workshop.

While in Canberra, why not attend the international exhibition "Rauschenberg and Johns" at the National Gallery, or the moving National Photographic Portrait Prize at the National Portrait Gallery next door. Alternatively, just enjoy spring in the beautiful outdoors of our nation's capital.

Dr Bibhuti Thakur
Convenor

Dr Adam Eslick
Co-Convenor

Western Australia

CONFERENCE

The ACE WA Country Conference will be held from the 28-30 October at the Pullman Resort in Bunker Bay. The theme is "What's new in '22?" and is convened by St John of God Midland Public and Private Hospitals with the WA ACE CME Committee.

Dr Michael Paech will provide an obstetric anaesthesia update, Dr Leena Nagappan will be providing a perioperative medicine update and Dr Neil Hauser will share updates from the ANZCA ASM 2022. Dr Ted Murphy will speak about anaesthesia in the digital age; Dr Steven Webb will present about randomised embedded adaptive platform trials in relation to best treatment of severe COVID; and Dr Hannah Seymour will speak about the WA NOF Registry.

The social calendar includes a welcome dinner at the Pullman Resort and an evening at Wise Winery. A mini-conference for children will be held on the Saturday afternoon with more details to come!

PRIMARY EXAMS

The WA ANZCA staff hosted their first exam at the new premises at the Garden Office Park on the 8 March, when the primary written examinations were conducted. We congratulate the candidates who were successful in their primary examinations; in particular Dr Alexandra Carle who was awarded the Renton Prize, and Dr Declan Scott who received the merit award!

FINAL EXAM PREPARATION COURSE

The Final Exam Preparation Course is well under way. If you are a trainee studying for your final exam and would like some further tutoring, please visit the ANZCA Calendar for the WA Final Exam Preparation Course registration page.

TRAINEES

Trainees can contact the members of WA Trainee Committee confidentially. If you have any queries or concerns that you would like to discuss with a member of the WA Trainee Committee, you are welcome to contact them direct via their private email: anzca.watc@gmail.com.

Queensland

TURRBAL BLESSING

As part of a college-wide initiative, the ANZCA Queensland office has paid respects to the traditional laws and customs of the Turrbal Peoples by renaming the two meeting rooms in the local language.

Songwoman Maroochy, Elder of the Turrbal tribe, was invited to the ANZCA Queensland office to deliver a Blessing of the Gathering, which included a traditional song, a short speech on the Turrbal people's history, a snippet of the Australian national anthem in Turrbal language, a sacred blessing song in Turrbal language, and the unveiling of the new meeting room names.

Boardroom – murumbah yakka, "work in the spirit of goodness"
Riverview Room – magul mianubba, "eyes of the mind"

The ceremony was held on Thursday 21 April, and was attended by members of the ANZCA Queensland Regional Committee, and special guest Immediate Past President Dr Vanessa Beavis.

From left: Blessing in murumbah yakka (formerly boardroom). Songwoman Maroochy and Dr Vanessa Beavis. Dr Paul Lee-Archer, Dr Sean McManus, Dr Christopher Stonell and Dr Vanessa Beavis.

COURSES

Despite COVID restrictions and severe weather and flooding in Brisbane in February this year, the Queensland final exam refresher course was still able to be held. A big thank you to convenor Dr Stuart Blain, and all the presenters and attendees, for the tremendous efforts in keeping the course running. The five day course was held virtually for the first three days, and the final two days were held in hybrid format thanks to the Queensland Children's Hospital facilities.

The primary and final practice viva evenings have been a big focus in April and May, with four sessions being held face-to-face in the ANZCA Queensland office, and additional virtual sessions for regional trainees who were unable to attend face-to-face. Thank you to convenors Dr Larissa Cowley and Dr Hannah Bellwood, and to all the mock examiners who assisted with the courses.

Left: Dr Paul Lee-Archer presenting his talk at the Queensland Children's Hospital.

CALL FOR MOCK EXAMINERS

Our exam preparation courses can make a real difference to candidates' preparedness and performance. For many fellows, sharing their knowledge and experience with the next generation of specialists-in-training is one of the most meaningful ways to make a difference to the future of the profession.

We would love to hear from Queensland fellows who are interested in assisting with the delivery of primary and final practice viva courses. For more information please email Karan Shah at qldcourses@anzca.edu.au.

Victoria

COURSES

It's heart-warming having ANZCA House buzzing once again with courses being delivered face-to-face, a year after COVID pandemic closure.

We were delighted to meet lots of new trainees at the recent Primary Refresher Course (16-27 May) in person and those who joined our growing online learning community.

Trainees had the opportunity to hear from 29 leading clinicians including the Primary Refresher Course Convenor, Dr Adam Skinner, who brought a group of specialists together to deliver talks in their area of expertise. This 10-day training course included sessions on pregnancy, equipment, safety electrical hazards, crossing the book brain barrier, opioids, transfusions, local anaesthesia, neuromuscular junction and blockers.

Among the presenters was Dr Tracy Jackson, a specialist anaesthetist at Monash Health, speaking on one of the oldest challenges in history of medicine: Pain. Dr Jackson discussed the physiology of the pain pathways and how drugs may regulate the perception of pain. Trainees also reviewed sample questions, providing helpful dialogue and discussion around the types of intravenous analgesic drugs that might be administered on a particular patient.

In the second week of the course, trainees delved deep into the respiratory physiology with Dr Stanley Tay, a staff specialist at Western Health, honorary clinical lecturer at the University of Melbourne and a Renton Prize recipient in 2008. Dr Tay unpacked concepts related to mechanics of breathing, muscles of respiration, fast versus slow alveoli and physiological dead space, among others. Over a day and a half, trainees actively participated in discussions and received guidance with practice short answer questions as a way of fine tuning their responses and performance, which gets better with practice.

Over the past few months, Victoria has continued to offer Primary VIVA practice nights and Final VIVA practice nights online, and hosted a well-attended Victorian Anaesthesia Training Scheme (VATS) Information Evening.

From top: Dr Stan Tay with Primary Refresher Course trainees; Dr Mark Adams presenting.

EVENTS AND COURSES

Annual FPM Victorian Forum – save the date!

Save the date Victorian FPM Fellows for the Annual FPM Victorian Forum to be held on Wednesday, 27 July 2022 from 6.30pm to 8.30pm at the ANZCA College, Melbourne. Virtual participation also available. The focus of the meeting is to give Victorian FPM fellows the opportunity to raise critical local issues, identify emerging challenges and opportunities for the FPM Executive and FPM Board to be aware of over the next 12 months. More details to follow soon.

- **Final Exam Refresher Course**
  Monday18 – Friday 22 July
- **Final Anatomy Course**
  Monday 25 July
- **Melbourne Winter Anaesthetic Meeting**
  Saturday 30 July (scientific meeting) and Sunday 31 July (workshops)
- **CME Evening Meeting**
  Thursday 11 August
- **Quality Assurance Meeting**
  Date to be confirmed in September/October
- **Mountain to Murray (Beechworth)**
  Friday 7 October (evening drinks), Saturday 8 October (scientific meeting) and Sunday 9 October (workshops)
- **Victorian Registrars' Scientific Meeting**
  Friday 4 November
- **Primary VIVA practice**
  3, 4, 5, 10, 12, 18 and 19 October
- **Final VIVA practice**
  24, 25, 26 October, 2 and 3 November
- **Primary Exam Refresher Course**
  Monday 14 to Friday 25 November

For further information contact the Victorian Regional Office via email vic@anzca.edu.au – or call +61 3 8517 5313.

Tasmania

NEWS

As the first winter snow fell on kunanyi/Mount Wellington, the Tasmanian Regional Committee (TRC) was delighted to welcome ANZCA CEO Nigel Fidgeon to Tasmania after a pandemic-associated hiatus. In combination with the Tasmanian ASA Committee of Management we shared an enjoyable meal in north and south hubs and constructive discussion of local and national issues and activities.

The TRC has recently completed a nomination process for committee membership that sees the return of some familiar faces and welcomes some new members. Additional members are being sought for ongoing residual vacancies. The trainee committee also welcomes new membership for 2022 and is led by co-chairs Dr Stuart Paterson and Dr Lisa Allen.

CPD activities, advocacy and training continue to keep the TRC busy. The TATP has commenced its first selection process of 2022 for senior registrars and provisional fellows. The main selection process opens shortly and concludes mid-August 2022. Core advocacy activities focus on improving opportunities for anaesthesia and pain medicine in Tasmania including the current STP process and supporting the response to the accreditation issues raised for the Persistent Pain Service.

The recent Tasmanian Trainee Day 2022 was successfully held as an online event. Thanks, and congratulations to all involved, especially co-convenors Dr Bing Chan and Dr Dheeraj Sharma.

Dr Lia Freestone
Chair, Tasmanian Regional Committee

Join us

The TRC is seeking interested people to fill casual vacancies for 2022 and beyond. The committee is a busy, locally representative and inclusive committee with strong links to ANZCA. Working with the committee is a great opportunity to work with like-minded people, to be involved in the work of ANZCA and to contribute to our profession. It is rewarding and sometimes even involves a tasty meal. Please get in touch with TRC Chair Dr Lia Freestone, you will be welcomed.

UPCOMING MEETINGS

Put Saturday 20 August in your calendar for a weekend in northern Tasmania. The organising committee invites you to our meeting at the beautiful Josef Chromy Vineyard on the Southern outskirts of Launceston.

The theme of the meeting is "Keeping the glass half full". This reflects the delight of the organising committee in presenting an "in person" meeting that can be delivered with certainty after several years of disruption. Delegates will enjoy sessions on a broad range of topics from local and interstate speakers including regional anaesthesia, pain medicine, medical education, social media and more. The meeting will be closed by Mr Chris Barnes, the head of the viticulture program at Melbourne University to give us an update on the state of the wine industry in Australia. His presentation will seamlessly blend into pre-dinner drinks and a three-course dinner at the on-site award-winning restaurant.

Registrations are now open!

Ryan Hughes MBBS FANZCA
Staff Specialist, Anaesthesia
Launceston General Hospital

CPD IN A DAY

Registrations are now open for "CPD in a day" to be held at the Medical Science Precinct in Hobart on 5 November. The courses being held are emergency response workshops including ASBD; CICO; ALS and major haemorrhage and possibly ASBD (pending confirmation of a facilitator being able to come to Tasmania).

We are excited for the workshop day – it's a much needed meeting in Tasmania. A fun and relaxing social gathering will finish off the day at Boodle Beasely in North Hobart.

Dr Nat Jackson and Dr Harry Laughlin
Co-Convenors

2023 TASMANIAN ACE ASM & TRAINEE DAY

Head south for an exciting summer meeting next year! Hobart will be hosting the Tasmanian Annual Scientific Meeting over 25 and 26 February 2023. Over two days we will be "Making Connections" through a day of lectures and a day of workshops, exploring the realms of airway management, perioperative medicine, pain management and sustainability. Keynote speakers Professor Bernhard Riedel from the Peter MacCallum Cancer Centre and Dr Suyin Tan from Nepean Hospital will be sharing their wisdom along with local speakers. Our local speakers will be providing insights into Tasmanian challenges and updates in perioperative medicine, airway management and regional anaesthesia. The new venue, the Hotel Grand Chancellor will ensure a spacious, COVID safe but social environment, and our social function, a cocktail style affair enjoying water views, will be held at the renowned Aloft Restaurant. Registrations will open in November. The annual Trainee Day will again be preceding the meeting on Friday 24 February 2023 at Hadley's Orient Hotel.

Dr Jana Vitesnikova and Dr Stephanie Cruice
Convenors of the 2023 Tasmanian ASM

New South Wales

NEW SOUTH WALES COURSES

In the first half of 2022, we successfully delivered four virtual Primary Exam Practice viva nights for 50 trainees.

We would like to extend our special thanks and gratitude to all the four participating hospitals, convenors and examiners for their time and dedication in supporting our Primary exam trainees.

- **Royal Prince Alfred Hospital**
  Tuesday 5 April 2022
  ANZCA NSW and the NSW Trainee Committee would like to thank convenor Dr Mark Porter and 15 examiners on delivering a successful practice viva evening for 15 trainees.
- **Royal North Shore Hospital**
  Tuesday 12 April 2022
  ANZCA NSW and the NSW Trainee Committee would like to thank convenor Dr David Fahey and 12 examiners on delivering a successful practice viva evening for 11 trainees.
- **St Vincent's Hospital**
  Wednesday 27 April 2022
  ANZCA NSW and the NSW Trainee Committee would like to thank convenor Dr Angela Walker and 10 examiners on delivering a successful practice viva evening for 10 trainees.
- **Westmead Hospital**
  Wednesday 27 April 2022
  ANZCA NSW and the NSW Trainee Committee would like to thank convenor Dr Jessie Ly and 14 examiners on delivering a successful practice viva evening for 14 trainees.

Additionally, we would like to thank convenor Dr Anthony Notaras and the NSW Trainee Committee for their remarkable support in delivering the Primary Practice Viva nights.

New South Wales Final Exam Practice Vivas

In the first half of 2022, we successfully delivered four virtual Final Exam Practice viva nights for 36 trainees.

We would like to extend our special thanks and gratitude to all the participating hospitals, convenors and examiners for their time and dedication in supporting our Final exam trainees.

- **Concord Repatriation General Hospital**
  Monday 16 May 2022
  Final Exam Refresher Course Convenor Dr Sally Wharton and the ANZCA NSW team would like to thank convenors Dr Kathryn Brooker and Dr Rebecca Lewis, along with 11 examiners on delivering a successful practice viva evening for 13 trainees.
- **St George Hospital**
  Tuesday 17 May 2022
  Final Exam Refresher Course Convenor Dr Sally Wharton and the ANZCA NSW team would like to thank convenors Dr Tim Cooper and Dr Michael Tobin, along with 13 examiners on delivering two successful sessions in one evening for 11 trainees.
- **Liverpool Hospital**
  Tuesday 17 May 2022
  Final Exam Refresher Course Convenor Dr Sally Wharton and the ANZCA NSW team would like to thank convenor Dr Alex Chau and 10 examiners on delivering a successful practice viva evening for a large group of 10 trainees.
- **John Hunter Hospital**
  Tuesday 17 May 2022
  Final Exam Refresher Course Convenor Dr Sally Wharton and the ANZCA NSW team would like to thank convenor Dr Simon Gomes-Viera and 4 examiners on delivering a successful practice viva evening for 4 trainees.

DR ANDREW COUCH MEMORIAL AWARD

The Dr Andrew Couch Memorial Award is awarded to a resident, registrar, provisional fellow or fellow within one year of admission to fellowship of ANZCA who has been involved in an audit or original research related to anaesthesia within their workplace. Following the outstanding presentations at the 2022 NSW ACE Winter Meeting on Saturday 18 June, the 2022 Dr Andrew Couch Memorial Award has been awarded to Dr Benjamin Pons for his presentation "Antibiotic Allergy De-labelling in the Perioperative Setting".

SAVE THE DATE

- NSW ACE Spring Meeting Terrigal –
  Saturday 12 and Sunday 13 November 2022
- NSW ACE Anatomy Workshop
  Sydney – Saturday 26 November 2022

From left: Dr Sally Wharton, Dr Sharon Tivey, Dr Jo Walsh, Dr Niranjali O'Connor and Dr Candice Peters.

SUPERVISORS OF TRAINING MEETING

A supervisors of training meeting for NSW and ACT was held in March – as always, a great opportunity to meet up with fellow SOTs.

Dr Maggie Wong attended via Zoom for an update on DPA matters, and Dr Robert O'Brien was able to attend in person – so time to chat more informally (and answer more questions!) over lunch and through the day.

In the afternoon there was plenty of discussion, when we were joined by Dr Michelle Moyle, who together with Dr Frances Page is leading a working group exploring the feasibility of centralised recruitment in NSW. She explained the processes around that, including proposed changes being considered.

Dr James Nielsen is now a new deputy education officer for NSW, replacing Dr Adam Eslick who moved to Canberra last year.

Thank you Adam and welcome James!

Sally Wharton
Education Officer, NSW